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Recent Advances in Preventive Medicine

By Dr. F. W. JACKSON, Deputy Minister of Health for Manitoba.

Those of you who are fond of poetry will probably remember Tennyson's "Idylls of the King," and particularly that bit which runs something like this:

"The old order changeth, yielding place to new,
And God fulfils himself in many ways."

We might paraphrase this to read:

The old order changeth, yielding place to new,
And the State fulfils itself in many ways.

A few centuries ago the only duty of the State appeared to be to collect taxes for the upkeep of those in authority. All this has changed, however, and now we find that a very small percentage of the moneys collected as taxes are used for the glorification of those in power.

At first, when the common people demanded that the money so collected should be used, at least to some extent, for themselves, no apparent thought was given to any except those who paid the taxes. By this I mean that the money so allocated was used practically entirely for the benefit of the fit and well. The care of the sick and afflicted was left entirely to charity. If one was able to beg, he collected the benevolence of the more fortunate in his community.

All these are things of the past, however, and now we find that the State considers it has a duty to perform, not only to the well, but also to the halt, the lame and the blind, and it even goes farther and considers it has a duty towards the destitute, the motherless and the homeless within its gates. So "the old order changeth" and the State fulfils its duty to its citizens in many new ways. In this scheme of things the health of the people plays an increasingly important role.

Public health was probably the first of these new movements to receive much serious attention from those in authority. The protection of the health of the people, as we know it, was originated at the time of the passing of the Consolidated Public Health Act in Great Britain in 1875. This paved the way for practically all advances, especially from an administrative standpoint, that have been made up to the present time. It is the foundation upon which is built all efficient health departments, and although when first brought into effect it was only meant to regulate the metropolitan area of Great Britain, particularly in reference to sanitation, it has been added to and amended since that time until now it embraces all branches of public health activities.

It is interesting to follow the evolutions of public health. In the first place the protection of the health of the people was thought to consist of the segregation of those actually suffering from communicable disease, and the proper disposal of the bodies of those whose death was due to some malady of an infectious nature. Not much stock was taken of contacts until it was found that contacts of cases, in the great majority of instances, contracted the disease. Then we had rigid quarantine. No attempt was made, however, to separate the sick from the well, and the disease was allowed to run its course until all the members of the family who were susceptible had contracted it.

(An address delivered before the First Conference on Social Work in Manitoba, by Dr. F. W. Jackson, Deputy Minister of Health for Manitoba, and formerly Director, Division of Disease Prevention, Department of Health and Public Welfare, Manitoba.)

It was about this time, during the Great Plague in London, that the authorities started to make a determined effort to mark all houses in which a case of the disease occurred, which they did with red chalk, and then set a watchman to see that no one entered or left the place. This was the forerunner of the present-day placarding. At that time, however, the regulation was received with great bitterness of feeling by those among the population who did not understand such an action and who felt they were being made "prisoners of the plague." To escape being put under quarantine, they refused to report the existence of illness in their homes, consulted quack doctors instead of physicians so the authorities would not learn that illness had appeared among them, and in many other ways tried to hide the fact. At one time a mob, led by a man mad with grief and terror, rushed about London killing and frightening off the guards, breaking open the houses and calling to the inmates to come forth and no longer be "prisoners of the plague." The authorities had difficulty in dispersing this mob and placing the leaders under restraint. However, instead of being discouraged, the authorities only enforced their decrees more rigorously as they realised this was the only means at their disposal whereby they might control the disease.

The next advance was the isolation of the patient actually suffering from the disease, in addition to the quarantine of all the members of the household. This still holds good in present-day practice, particularly the isolation of the patient.

About this time there had been a means demonstrated whereby at least one disease could be prevented. I refer to Jenner's discovery in reference to smallpox prevention.

Science progressed, and as knowledge of the causes of disease widened, the fact became evident that to control epidemics or try to prevent the spread of disease was not enough; rather we should try to prevent the disease from occurring, or, in other words, to practice preventive medicine.

The great discoveries of Pasteur in France, and Klebs, Loeffler and Koch in Germany, in which they demonstrated the organisms as the cause of various communicable diseases, marked another forward step, and it is upon this foundation that our present-day knowledge of immunisation for disease prevention firmly rests.

Through all this period sanitation as a factor in the occurrence and spread of disease was becoming more pronounced, and with the establishment of proper water supplies and sewage disposal systems, water-borne diseases gradually became less of a problem in all well-organised urban communities.

As public health workers came to understand more about communicable disease, both as to the cause and methods of spread, schemes were worked out which have resulted in practically eliminating certain of these diseases from civilised countries. I refer particularly to yellow fever and malaria. These two diseases have been controlled, of course, by the elimination of the particular mosquitoes which in each case are responsible for the spread of the disease.

With the preservation of health by means of immunisation we enter an entirely new field. As I have mentioned before, the discovery by Jenner of vaccination for the prevention of smallpox was a forerunner of our present-day use of immunity-producing agents. These are now becoming more or less legion.

For diphtheria we have, in the first place, diphtheria antitoxin, which will give immunity to an individual for a period of from four to eight weeks. Then we have diphtheria toxoid, which will give permanent immunity in approximately 90% of individuals treated.

We have scarlet fever antitoxin, which gives a like period of immunity against scarlet fever that the diphtheria antitoxin gives for diphtheria; and we have scarlet fever toxoid,

which some claim is of nearly as much value in giving immunity against scarlet fever as toxoid is for diphtheria. This, however, has not been definitely established.

We have a vaccine for whooping cough, which is worthy of a trial to protect contacts of this disease. No doubt now remains of the possibility of controlling measles by the use of convalescent serum, and we have a vaccine for protection against typhoid which was of untold value for the prevention of this disease during the Great War.

In many places measles, in so far as it is a cause of death, is pretty well controlled by the use of convalescent serum. This entails a considerable amount of work and, in view of the fact that a great many people consider measles as only a trifling disease, widespread use of convalescent serum has not been made.

Convalescent serum can be obtained from anyone who has ever had measles, and it has been definitely proven that a small dose of this serum given to an individual within one week of being in contact with the disease will prevent the occurrence of the measles in 85% of cases, whereas 85% of those who come in contact with measles, if they have not had the disease at some previous time and have not had serum, will contract it.

In view of the fact that when measles is epidemic in our province the deaths from this cause exceed those from scarlet fever, and do not fall far short of those from diphtheria, it would seem that we should take advantage of this method of preventing the occurrence of cases, especially among the younger members of our population.

You will probably remember that twenty years ago typhoid fever was a common malady during the summer and fall months in Winnipeg. Our hospitals were filled to capacity with patients suffering from this disease. Now it is difficult to find enough cases of typhoid to properly instruct the students in the diagnosis and treatment of this disease, and those that are available are generally from outside the city. This great improvement, we must admit, has been brought about by the great improvement in the environment in which we live, but in addition to this the use of typhoid vaccine has played a very important part in the control of this disease. In an epidemic which happened in Northern Manitoba during the spring of 1929, out of seventy-odd cases which occurred not a single one had had typhoid vaccine; whereas a great many other individuals who had had the vaccine and the same chance of contracting the disease did not develop it.

As you probably know, a regulation was brought into force giving the Department power to order the compulsory use of typhoid vaccine in all those engaged in mining, lumber and construction camps. This was done in Northern Manitoba in June, 1929, and since that time, despite the fact that the germs of the disease are seeded over the length and breadth of the north country as a result of the epidemic in the spring of 1929, we have only had four cases of typhoid reported from this area, and in every instance these occurred in individuals who had not been given vaccine.

We think, despite the improvement in the sanitation in this north country, the chlorination of the water, etc., the major reason that typhoid has become comparatively a thing of the past is that almost the entire population north of 53 has been immunized against this disease.

In so far as diphtheria is concerned, it rests entirely with ourselves whether or not we have this disease with us. The last fifteen years have definitely demonstrated that we have a simple, safe and comparatively sure method of preventing this disease. I refer to the administration of toxoid. Already in Canada some 800,000 children have been protected against diphtheria by the use of this agent, and in all those two and a half million doses there has not been one untoward result reported. France has administered some twenty million

doses of this material, and in their case also there has not been a single untoward result reported.

Many communities which have taken it upon themselves to take some stock in the prevention of diphtheria have found that they have been able to practically eliminate this disease as a cause of disability and death.

One cannot see why objections should be raised by any individual or community against this simple, safe and comparatively sure method of protecting the child life of our country against the ravages of this dread disease, and the more one looks into the possibilities the more one becomes convinced that a little effort on the part of the Department and cooperation on the part of the people in the province will make it possible to almost entirely eliminate cases of diphtheria in our province, and certainly entirely remove it as a cause of death. As the yearly average number of lives lost from this disease during the last ten years has been 99, no serious-minded citizen can afford not to advocate the use of toxoid as a protection against diphtheria.

Although public health has advanced remarkably during the last twenty-five years, there is one point on which we have retrogressed. I refer to the abolishment of compulsory vaccination against smallpox. A very cursory glance at the Epidemiological Reports of the League of Nations, which show the occurrence of communicable diseases in the various countries of the world, will very clearly demonstrate the fact, as it is found in those countries where vaccination is still compulsory, that small pox practically never occurs, while in other countries, such as Great Britain, Canada and United States, where vaccination is only compulsory in the event of an epidemic, we find the number of cases occurring really appalling, and we can rest assured, before many generations have passed, if vaccination is allowed to lapse, we will have again the high case and death rate that prevailed in the time preceding the discovery of vaccination by Jenner.

With regard to tuberculosis, there is one side of the question which interests me. I refer to the Grancher system for the protection of childhood against tuberculosis. This was started in France in 1903, and the province of Quebec decided last year to put it into operation. It would appear that it is working out successfully in this province, and it has occurred to me that it might be of value to our own. The health workers in Quebec are very enthusiastic about this system and feel convinced that within the next generation it will have a direct effect in lowering the death rate from this disease. The whole idea of this scheme is to remove well children from T.B. infected homes and place them with foster parents in homes free from the disease. The cost of this is borne by the Department of Health and the funds available for the work are practically unlimited.

If we made full use of our present knowledge in reference to disease prevention by immunization only, we could save at least from 125 to 150 deaths a year in Manitoba, in addition to the untold suffering and disability engendered by measles, whooping cough, scarlet fever, typhoid, diphtheria and smallpox.

In closing, might I leave this thought with you? The welfare of our people does not depend on the efforts of any one branch of social service alone, but by a combination of all our activities and the exchange of knowledge and practical ideas we may hope to make Manitoba the best province in which to *live young and die old.*

Life in Canadian Labrador

By ISOBEL FLEMING, Winnipeg, Manitoba.

Life is spent in incidents and time between incidents. In Labrador the time between seems very short, for Labrador days are filled with incidents of intense interest. There is no time or excuse for loneliness, that is, in summer. Winter has a different tale to tell.

It is usually the first of June before the great floes of glacial ice are carried away from the coast by the Arctic stream. Then navigation is opened. Five miles from our town —Harrington Harbour—stands the telegraph station on the mainland, with which we are connected by a single three-party telephone. From this we receive many rumours about our old friend the freight and passenger steamer which brought us north from Quebec the year before: as also many tales of schooners coming from Halifax with provisions. Finally, after much anxious waiting, the first ship arrives. More than six months have passed since her last visit in the previous November.

The whole town welcomes the arrival of the steamer, for it not only brings news from the outside world, but also much needed supplies of canned milk, salt pork, flour, butter, molasses, hospital supplies, and especially that household god of the fishermen—Canadian Leaf Tobacco. This tobacco is grown in Quebec and has been used from the earliest times by the habitant. It is sold in large ten-pound bales; and once smelled it can never be forgotten!

In other lands spring is the beginning of vacation for colleges and universities. From these come our summer staff of assistants: doctors, dentists, nurses, social workers, teachers and wops.

Newcomers are regarded with some suspicion. The conventional tourist-attitude receives little toleration from natives and old-timers; but a year or so makes one an old timer. Openly we sympathise with those who have been sea-sick, but secretly we scorn these inexperienced landlubbers who have just come from the city.

The relics of other days remain in many outlandish customs. Two weeks of the Christmas season are spent in what is called "mummering." Young and old array themselves in grotesque and humorous costume, serenade each other's homes and take toll of their hosts in the way of refreshment. And they receive a ready welcome: the latch-string is always out for any who care to enter. Indeed, Canadian Labrador, scattered community though it is, is almost like one large family; for the terms Uncle and Aunt commonly take the place of Mister and Missus. Even newcomers from the outside, or neighbours from 150 miles along the coast, soon learn to drop the conventional Mister or M'sieu (applied indifferently to French or English), and adopt the friendlier custom of saying "Uncle." Uncle Esau would be distinctly suspicious of the person who continued to call him "Mr."; and Uncle Jim would not hesitate to correct any one who dared such open disregard for the niceties of Labrador etiquette.

Another characteristic that strikes the uninitiated is the trading system. A freight, mail and passenger steamer makes the round trip from Quebec each fortnight of the summer months. Also English and French-Canadian schooners from Quebec and from Halifax regularly make three calls each during the course of the summer. In return for salt, foodstuffs, engines, guns, clothing and fishing-gear, the traders reload their ships with dry salt codfish. The typical trader still sails the seas in the old fashion. He does not bother with such vanities as schedules or time-tables. Steamers

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may come and aeroplanes may go, but his only concern is that the wind may blow for ever without taking toll of him or his ship. He does not even use an auxiliary engine. His business methods also are equally lacking in the modern ways of efficiency: he is too busy in the running of his romantic ship and the ordering of his crew to give much attention to prosaic book-keeping.

In the various villages along the coast there are a few stores: some, Hudson's Bay Company posts, others, privately owned. Next to the ship's cabin, the store is an excellent place to spend a day, especially in the spring, when news from the outside world is passed around with that famous leaf tobacco. Here, on cabin shelves or the store "backshop," there is everything from a needle to an anchor to be exchanged for furs or cash, or credit on the coming season's catch of codfish.

In the city, men are not so easily lured to the market by a display of plain goods, nor is any opportunity given in the city store to spend a sociable afternoon talking about the ways of the world with one's neighbours. It simply is not done. Nor is one invited to "stay awhile" when the business is finished. In Labrador it is different. The purchasers have often come from a great distance by boat; and they are accustomed to buy enough tobacco and flour and fishing twine to last half a year, with perhaps a whole summer or winter outfit for the family. Who will blame them if they take a week or so each time they are outfitted?

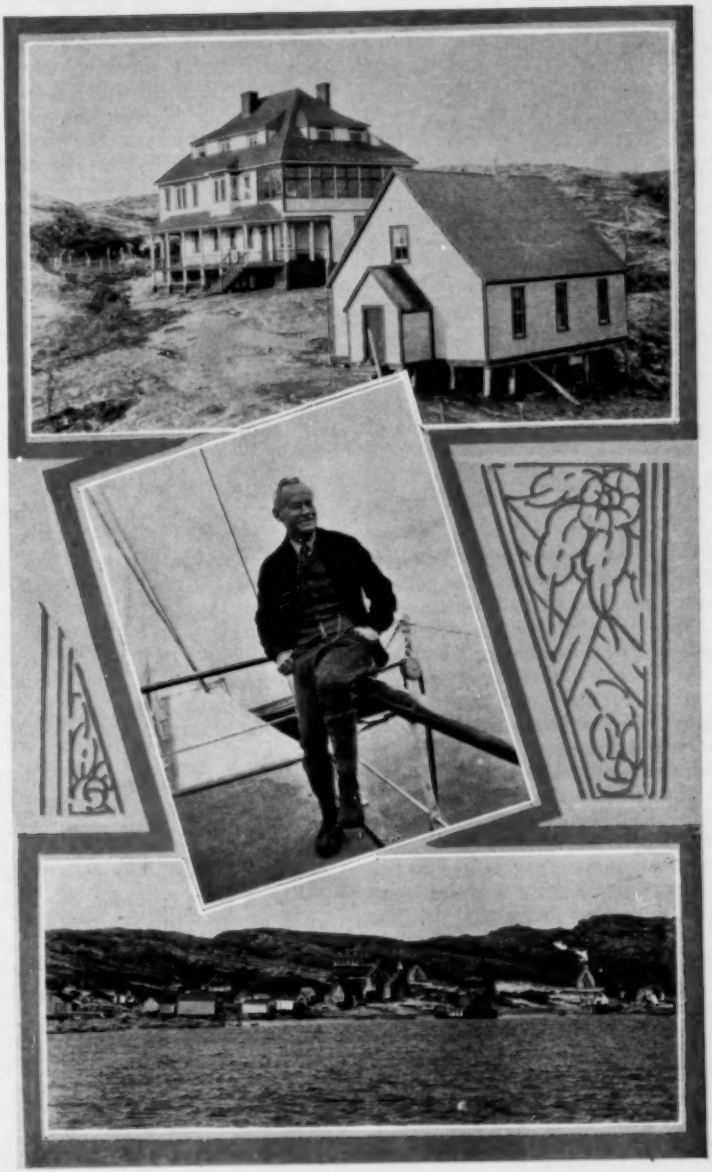
The wilds of Labrador have become proverbial, but we have also heard of their lure. Behind the bleak inhabited coast is the great unexplored and almost impassable mountainous interior: a mysterious peninsula of over four hundred thousand square miles.

Along the coast the climate does not differ much, for it depends less on latitude than on the ocean currents. The cold Arctic current, with its vast burden of blue glacial ice, sends the thermometer creeping down into its winter shelter. The fishermen learn a lesson from the thermometer, and leaving the exposed outer islands they gather in little groups in their warm winter cabins on the mainland.

The population of Labrador has varied greatly throughout its history. There are clear indications to show that, long before Columbus discovered America, or Jacques Cartier sailed through the Straits of Belle Isle, this coast was frequently visited by the Norsemen. But the original inhabitants both of Labrador and Newfoundland were the Esquimaux. They had for their bitter enemies the nation of Algonquin Indians, who occupied the north side of the Gulf of St. Lawrence (Canadian Labrador), and who, on one occasion, were able to muster an army of six thousand braves to fight against them. Later, the Esquimaux suffered severely at the hands of the Palefaces, and were driven to the northern shores of the peninsula; so that today their territory begins about 250 miles north of the Straits of Belle Isle. The Moravian missionaries are said to have done marvellous work in civilising them.

Within the last few years Canada has been overcoming the Northland with radio and aeroplane, and her patrol ships have been establishing mounted police posts under the very shadow of the Pole. Also she has been justifying her claim to the Arctic regions by patrolling these vast territories of Labrador and bringing the Esquimaux under Canadian law. This does not apply, however, to the interior of the peninsula, which—especially since a recent British decision—has become the property of Newfoundland.

Someone has said that the real inhabitants of the rugged coast of Labrador are the birds. When one sails among these islands it is a beautiful and a frequent sight to see several thousand eider ducks flying swiftly over the surface of the water in a long line extending for a mile or



LABRADOR SCENES

more; or on a summer's evening the white-breasted murres and auks may be seen perched sedately on some rocky ledge. On one island of the Straits (not far from the famous Greenley Island of the unfortunate Bremen landing) thousands of puffins are nested. The puffin is a small sea-bird having some of the bright colouring of the parrot about the head and beak. The beak, too, is like that of the parrot, and is very powerful. It seems strange that these sea-birds, and other seagulls as well, should lay eggs larger than those of the domestic fowl. Many of the coast people gather the eggs in spring, gathering as many as a barrel of eggs for each family. Labrador is, of course, a paradise for the ornithologist and naturalist, and during the summer many students of bird life come to study these northern birds among the rocky crags of the islands, which have been set apart as bird sanctuaries.

The present population of Labrador, for 200 miles north of the Straits of Belle Isle and the same distance west along the north shore of the gulf, is mostly of English descent. Further west the French element prevails. In some districts there are many half-breeds, and on the Canadian Labrador there are numerous Indian settlements. In winter these Indians explore the interior to a considerable distance, hunting for the valuable pelts of fox, mink, mountain cat and ermine. In summer they return to the coast and live in little colonies near the Hudson's Bay Company trading posts. The English and French live, for the most part, in separate villages, ranging in population from fifty to four hundred.

Harrington Harbour, the headquarters for the Grenfell Mission, is a central English village in Canadian Labrador with a population of three hundred. This settlement is on a group of islands about five miles from the mainland. Approaching Harrington by sea, one observes a group of islands rising like Gibraltars high out of the water. These islands, like many others scattered along the coast, are formed of coarse red granite deeply scored, and covered in places by thick green moss and low shrubbery. The ship passes through the harbour's narrow winding entrance, with a perpendicular granite wall on the right, and suddenly one sees the quiet little village sheltered in the bowl of a semi-circle of hills. In the centre of the village rises the Grenfell Hospital, a large, square, three-storied building, and close to it are the Mission Hall and store, two Protestant churches, and a school building. Motor boats come out from all directions to meet us, and the anchor-chain has hardly finished its message of safe arrival when the boats begin to tie up alongside and the fishermen and the hospital staff clamber on board.

Going ashore we are greeted by a howling menagerie of dogs—the Labrador orchestra. These obstreperous animals provide many of the thrills of team-travelling in winter, and incidentally they drive many a housekeeper to despair by their inveterate thieving. Their power of endurance is attested by the fact that Commander Byrd took more than eighty of these dogs with him on his trip to the Antarctic.

As there are no roads in the village, we scramble over the uneven granite, or wade through soft moss, from the little wharf to the homes. Most of the houses are neatly built of logs that have been sawn by hand; for until recently all the lumber was cut with the old-fashioned pit-saw. In the white-washed workshop at the water's edge—everyone lives a few yards from the water's edge—may be seen an old fisherman with his sons building a boat. On the scaffolding is a log which the boys are sawing into lumber: the saw they use is much like the two-handled cross-cut saw, but is worked perpendicularly. To make lumber in this fashion is obviously a difficult and tedious job.

These people are dependent on the cod-fish harvest; and fishing is as

much a gamble as wheat-growing. When the cod-fishing fails, there is much poverty among the fishermen, who, even in fat seasons, can afford few luxuries. Of late years their situation has scarcely improved; for though they have gasoline engines for their boats and improved methods of trapping fish, they have now a great competitor to threaten their livelihood —the steam trawler—which can take from the sea tons of fish to the fisher's pounds. The days of the shore fisherman may be passing. But in the meantime the work of the International Grenfell Association continues. Whether the fishers can solve their economic problem in Labrador or may be forced to abandon the coast, they must have medical attention.

The hospital has two wards with five beds in each. There is a sun-balcony (with three beds), operating room, dispensary, laboratory, and doctor and dentist's offices: quite a complete little medical station. There may be few patients in hospital—possibly between five and ten; but much of the doctor's work lies in attending to the villages along three hundred miles of coast. In summer he travels with the dentist in a little white launch, the *Northern Messenger*, and in winter he travels by dog-team.

The Grenfell Hospital at Harrington was established in 1908. It is maintained by Canadian capital, and as far as possible its staff is also Canadian. The permanent staff consists of doctor, nurse, housekeeper and local helpers. In summer these are supplemented by an assistant doctor, a dentist, and a couple of university boys called Wops, who are in search of thrilling experiences and make themselves generally useful.

Travelling in Labrador is a sure road to adventure. Excursions have to be carefully planned several days before making a trip of even a few miles.

For some time I had wanted to visit a nursing station at Mutton Bay, forty miles east of us. It was midwinter, and the doctor was arranging to start on his eastern trip as soon as weather permitted. Our driver, Uncle Esau, had a fine team of dogs ready and in good condition for several weeks of travel. I was warmly clad, Labrador fashion, in a white cossack with fur-trimmed neck, and hood and breeches of a closely-woven duck material which was wind and waterproof. My mocassins were tanned sealskin, which reached to the knees, somewhat like a rubber boot, closed at the top with a draw-string. The doctor and the driver were similarly outfitted. The komatik, a ten-foot dog-sled, had the customary provision box lashed on with sealskin thongs: this box served also as a seat. Each of the nine dogs was in sealskin harness, and on a separate rawhide trace. When we were ready to go, the lead dog was shown the direction by the driver pointing his whip and shouting "Raddah, Raddah," to indicate the left, or "Ek, Ek," for the right. The dogs needed no urging, for they were howling to be off. They started at amazing speed, but soon slowed down to a steady run, which they continued till we reached Aylmer Sound, ten miles distant. Here we stopped to attend several cases, and before our work was done the day was too far gone for further travel. We spent the night pleasantly enough. The hospitality made up for the discomfort of the undersized feather-bed, and a healthy appetite found small cause of complaint in the plain fare of salt fish or seal steaks, with potatoes, jam from native berries, and strong tea with canned milk.

We had been travelling from the outer islands to the mainland. Next morning we headed again towards the islands and the open sea. It was still early in the day when we arrived at the little French village of Whale Head. Again we attended some cases, but as the weather showed some signs of storm we hastily continued en route for Mutton Bay. As we travelled the men took turns at running beside the komatik. Occasionally I, too, would take a turn at the running, for

the deep snow made travelling slow and laborious, and running at least kept one warm. While riding, it was found better to sit with one's back to the dogs, for we were running into the rising storm. While seated in this manner the komatik gave a sudden lurch and threw me off headlong into the snow. This was a great source of mirth to my companions, and even the dogs enjoyed the slight diversion.

After travelling several hours through the storm we realised that we were lost. If we had followed the trail we should have reached Mutton Bay by this time; but Uncle Esau could find no landmark. The trail should have led through a narrow pass between the rugged hills which guard the entrance to the bay. We zig-zagged for hours between numberless islands, trying to pick up the trail. When we finally realised we were lost we had unpleasant recollections of a little wooden cross we had passed earlier in the day: a grim memorial erected on a bleak island to a young lad who, the previous year, had lost his way and frozen to death. We knew the pass was not far away, but were unable to find it. Finally we were forced to stop; and setting up the komatik in a clump of spruce trees for a shelter, we prepared to spend the night. A fire was built, and strong tea with stale bread did much to raise our spirits. As the fire scarcely kept us warm, we moved about to gather wood for the fire and at the same time to keep up our circulation. Meanwhile the dogs lay curled up in the snow, sleeping where they had been loosed from the komatik, and the falling snow soon turned them into huge snowballs.

Shortly after midnight the storm passed, and the moon rose in a clear cold sky. Uncle Esau donned a pair of snowshoes and set out to reconnoitre. In a short time he returned to tell us that the pass we had sought in vain was just over the hill. We had camped almost at the entrance! We at once re-hitched our team. The deep snow made progress extremely difficult, but we soon reached the nursing station, where there was warm food and fire and—incomparable joy!—soft beds and peaceful sleep.

On another occasion—this time in mid-summer—we decided to try our luck at cod-fishing. Immediately after supper we donned rubber boots, coat and hat, and borrowing a motor boat and fishing gear we headed for Gull-cliff Island to provide ourselves with bait. In half an hour we passed round the cliff, where twenty boats were already anchored, tied bow to stern. We tied up at the end of the line, and were soon followed by others. There was much shouting and good-natured horseplay among the men. Some jumped from boat to boat, climbed the mast to descend again head-first, and performed other pranks and stunts. It was dusk when our baitfish, the squid, arrived on the scene. The squid is a peculiar fish, with tentacles waving about its head. In the twilight it comes in swarms to the surface water, where it is caught with a specially designed rosette jigger. It clutches the jigger with its tentacles and is at once pulled from the water, and as it rises above the surface it shoots a stream of black fluid into the air, or into the face of the unsuspecting novice. The fishermen love to tell you that this is the secretary fish, and, cutting one open, they show the beautiful, white, paper-like flesh. Then the transparent backbone is skilfully removed: that can serve as a pen-quill. Beside the backbone one sees a long sac of black fluid, which the fishermen call ink. In reality this is what the squid throws in the face of his enemies in the manner of a smoke-screen.

Another day we took our borrowed motor-boat and proceeded to the fishing banks, five miles distant. The chief trapping season was past, when the fishing crews commonly catch several tons of fish in one haul: now hook, bait and line were used. After fishing for some time and getting a few fine cod, we began to weary of our sport, especially as the fish, once they

were caught, made no fight to get away.

After visiting some of the fishing boats we started homeward. The sky had been dull and threatening, and as we headed for the home harbour a heavy fog settled over us. A fog on land is often weird, but at sea, with nothing visible but a small circle of rough water about the boat, the phenomenon is distinctly unpleasant. It was necessary for one of us to sit in the bow of the boat and to peer into the fog for signs of shoals. The minutes passed slowly, and we progressed as slowly. Great was the relief of our boatload of amateur seamen when the steep entrance of the harbour loomed up before us in the fog and we finally arrived at the familiar landing.

Scarcely had we reached shore when we heard a ship's foghorn blowing at the mouth of the harbour. In a few minutes a beautiful white steam yacht came swiftly toward us, like an apparition, out of the fog. Great was the excitement, for it was Dr. Grenfell's yacht, the Strathcona II. As soon as anchor was dropped, we went on board and took Dr. Grenfell and his staff ashore. He had not been expected, but was doubly welcome to all of us. His plain clothes and plain manners did not hide the splendid personality of that practical idealist; and some of his unbounded enthusiasm passed into us. He regaled us with endless "experiences," spiced with wit and sympathy. In the evening he chatted with a group of the townsfolk who gathered around him in the mission hall. The next day, Sunday, he conducted "prayers" in the little United Church at the water's edge. On Monday morning early—good seamen start early—his yacht sailed majestically out of the harbour with colours flying, leaving all of us inspired with the doctor's great Vision of Service.

An Appreciation

The staff at National Headquarters appreciated exceedingly the numerous greetings and messages of good wishes received from International Headquarters, member organisations of the International Council of Nurses, and many individual nurses, during the Christmas Season.

Numbered among these greetings was a delightful card from Mrs. Rebecca Strong, of Edinburgh. Canadian nurses will be especially pleased to learn that Mrs. Strong continues her interest in nursing and has many happy memories of her visit to Canada during the Sixth Congress of the International Council of Nurses.

Dame Maud McCarthy, who visited us in 1926 for the unveiling of the Nurses Memorial, is another of our former guests from whom we heard lately. Dame Maud, following the unveiling ceremony, made a trip to the Pacific Coast, visiting one or more cities in each province, and she refers with enthusiasm to her visit to us when sending her best wishes for 1931.

The Staff at Headquarters, on their own behalf, and also for the Canadian Nurses Association, wish to express their many thanks for these kindly messages of good will.

Mental Hygiene for Nurses

By HARVEY CLARE, M.D., Superintendent of Homewood Sanitarium.

Mental hygiene is not the deep, mysterious, scientific subject that many of us think. It refers to the general mental health of the community. It also makes us ask ourselves the question, "Can the mental health of the community be improved?" The term mental hygiene makes us ask ourselves what we as individuals should do to lessen the evils that are caused by mental illness in our community.

These are big questions and can't be discussed fully in any single article. We know very well that in every neighbourhood there are occasional cases of mental disease, there are cases of retarded and backward children, and there may be cases of epilepsy. Besides these, there are all sorts of nervous, irritable, eccentric and emotional people.

I think we all believe that in order to raise the steady, sensible, confident child the parents must be of the same type. If the parents are of the emotional, unsteady, and erratic type, or if either of the parents are defective or psychotic, we must watch out for abnormal mental symptoms in the children. Many parents are of this abnormal type, and consequently we must expect the appearance of many abnormal types among the children.

I think it is safe to say that one in every hundred children born will show at some time a mental condition that will cause concern to his family. Some say that two or three in every hundred are feeble-minded, but, if so, the condition will not be so serious as to demand interference. One in one hundred may not seem to you a big proportion, but Canada has ten million people and one in one hundred would mean one hundred thousand of these people suffer mentally to such an extent that they need protection and assistance at some time.

The three conditions that cause this mental helplessness are:

Definite mental disease or insanity;

Mental retardation or feeble-mindedness;

Epilepsy.

The two influences that contribute chiefly to these conditions are heredity and environment. The breeding of animals proves to us that we get exactly the same kind of offspring as the type that we breed from. The Mendellian theory also proves that the hereditary influence is an actual fact. When we consider the influences of environment on the mental condition we are compelled to acknowledge that environment has as much influence as heredity, and we also realize that environment is much more easily controlled. Every child has a right to live and develop in an atmosphere that is full of sunshine, good nourishment, cheerfulness and free from all forms of irritation. We forget that children are often subjected to influences that warp their mental development. Babies are pampered, petted and humoured until they cry themselves black in the face. They are told ghost stories, and threatened with bears, witches and so forth until they are afraid to go to sleep or afraid to go into a room alone. Boys and girls are whipped at school because a question they can't do shows the wrong answer. They are ridiculed before the other members of their class because of something over which they have no control. They are scorned and humiliated because they may have to wear clothing that may not be as good as that of the other children. They are made to feel badly because they have not as much money for the penny bank as some more fortunate child. These mental traumas or injuries have very serious influences upon the mental condition of a child. He should have a chance to grow up self-confident, frank, open and free from deceit or secrecy. In the homes many children are merely machines, made to do certain physical work, but never consulted concerning their wishes or advised concerning

their problems. The parent is self-constituted an infallible god, and unquestioned obedience is demanded of the child. Some seem to think that this is a good condition. To me it seems that we should be trying to train the reason and self-control of the child. If he is never allowed to plan anything for himself or to think out problems for himself he will soon begin to think that he is inferior. If he does not use his intelligence and his judgment, these qualities will deteriorate from lack of use; the demand for unreasonable obedience will produce resentment, and the fact that other people are not placed in this unfavorable condition will make him jealous and envious.

The environment of crime or poverty will certainly stunt and warp the mental development.

What can we do to prevent the faulty influences of bad heredity and bad environment? Education of the general mass of people is the most important step: constant talking and constant writing will gradually get the people thinking for themselves on this subject. We must have organizations everywhere, drawing attention to the unhappy results of our present conditions. No organization of this kind would be complete without the social service nurse. No one can search out the hidden causes of mental unrest and mental unhappiness like a sensible and kindly nurse.

The nurse must understand these unhappy mental conditions, she must be familiar with them, she must be able to recognize them with her eyes shut. The only way to do this is to live with these mental cases, to eat with them, to sleep with them, to work with them, to get their confidence, to have them pour their unhappy stories into her trained ears. The social service nurse must be able to dig down and find the cause of their troubles and worries and in this way the children may be saved from many mental injuries.

I would say give me a good social service nurse who understands children, give her plenty of time and she will come back and tell me why a certain child is hard to control; she will tell me why another boy has been cruel to animals; she will tell me why a certain little girl tells lies without any cause; she will understand why the boy is at the foot of the class and why he refuses to play.

How are nurses going to qualify themselves for this important work? Only those nurses who are thoughtful, studious and interested will be successful. Granted that we have the right class of applicant nurse, I would suggest one month of actual ward work in a hospital for mental diseases, with lectures everyday on mental diseases; followed by one month of actual ward work in a hospital for feeble-minded children, with lectures everyday on these conditions; and two months of follow-up work from these hospitals. I mean by this, going out to the homes of the patients that are admitted and investigating thoroughly the conditions that exist there, then reporting back to the hospital as to the best remedy for the trouble.

Anyone going into this work must look upon the work as that of a missionary going to China, or a nun going into a colony of lepers. There is no honour in the work, there is any amount of trouble and abuse. Parents do not like their homes and children investigated and the nurse will be called a busybody and a snooper. The family doctor will soon complain that this nurse is interfering with his work. The municipal council will say that she is trying to run up expenses for them to pay. The results will be very slow and hard to see; after thirty or forty years work, she will, probably, be able to look back and say, "Things are a little better." If this work of constant education and investigation is kept up for one hundred years, conditions would be a lot better, but in the meantime, we must not become discouraged and we must remember that no one will be able to help us in this work as can the trained nurse.

Nursing the Mental Patient

By ESTHER M. NORTHMORE, Superintendent of Nurses, Homewood Sanitarium, Guelph, Ont.

The training of nurses for the care of the mentally ill is very important. The main fact to stress on the new and inexperienced nurse is that the patient is ill. This may be a little difficult at first, as many of the patients are well physically, eat and sleep well, and it is only experience that will teach the nurse that the patient is mentally ill. In the sanitarium we try to have these cases lead as normal a life as possible.

Qualifications of a nurse in this work are the same as in a general hospital. Education is essential, quickness of perception, tact and kindness, and the nurse must be conscientious. The nurse must have a sense of humour, so as not to take patients' worries too seriously. It is quite unnecessary to display warmth and affection and to coddle the patient or to use endearing terms when addressing her.

It is easier to nurse the mental patient away from her home, in a hospital or sanitarium, away from relatives and inquiring friends. Visitors should be limited, even in a sanitarium.

It depends very greatly on both the mental and physical condition of the patient just what nursing and treatment she will require. If she is well physically and able to be out of bed and going about, a schedule will be a splendid help to the nurse. A patient will be impressed and will usually try to follow it. The object of a schedule is to keep her busy and occupied, so she will not have time to sit around and think about her home and her condition.

It is better to start the day early. Breakfast 7 and 8 a.m. Permit the patient to rest.

9.30 a.m.—Spray bath, followed by a massage or electrical treatments or violet ray. Have her rest for half an hour.

10.30 a.m.—Get the patient out of bed and dressed and ready for a walk. Give some nourishment, liquid form, e.g., cocoa, soup, milk.

11-12 a.m.—Walk in the fresh air.

12-1 p.m.—Reading or occupational therapy.

1 p.m.—Lunch or dinner.

2-4 p.m.—Rest in bed, followed by nourishment or a cup of tea.

5-6 p.m.—Walk in the fresh air.

6.30 p.m.—Tea. After tea, reading or fancy-work; sometimes a moving picture or cards. Any amusement that will keep the patient occupied.

9.30 p.m.—A warm tepid bath, followed by a light massage and warm drink. The patient should be in bed ready for sleep at 10 p.m. or shortly after.

The nurse must make a schedule to suit her patient. If she is restless and cannot relax, the bath may last from half to one hour. The patient is never left alone while taking the bath.

If the patient is acutely excited and hallucinated, the treatment will be very different. It will be almost impossible to get her to co-operate. She will be restless, may be irritable and noisy, will not remain in bed. There is great danger of this patient hurting herself or becoming exhausted. The continuous bath treatment is very beneficial in these cases. It may be difficult to keep her in the tub. She is placed in the bath on a canvas cradle, with a rubber air pillow under her head and a canvas cover over the tub. The temperature of the water must not be below 96 or above 98 Fahrenheit. The water is kept at this temperature while she is in the tub. If the patient is not too restless and excited, cold compresses should be applied to the head every two minutes. These will be very soothing to her. The nurse will try and induce patient to drink plenty of water and take nourishment frequently during the bath. The length of time spent in the bath will depend upon the excitement of the patient. Sometimes these patients are removed for one hour,

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given a rest, and if still restless and excited, returned to the bath. The nurse must be in constant attendance. She must not turn her back on the patient in case the latter should put her head under the water or get out of the bath. The pulse must be watched constantly and must be recorded every fifteen minutes. Her colour must be watched carefully and on any signs of collapse she is removed from the tub immediately. The dangers of the continuous bath are: drowning, burning or chilling of the patient, exhaustion. The nurse must be very careful and watch the patient closely. When she is removed from the bath she must be rubbed thoroughly with a bathtowel, given a gentle alcoholic rub and put to bed and kept warm. Usually the patient will rest or sleep after this treatment. Hot wet packs are very beneficial, also massage and electrical treatments, walks in the fresh air if she is not too excited. Nourishment is very important in the nursing of these patients. The patient is very often too excited and busy listening to hallucinations and answering them; she may have delusions about her food, she may think that there is poison in it, and very often it is a difficult task for nurses to get a sufficient amount of nourishment in these patients. There may be times when she will be fairly rational for a few minutes at a time. The nurse must take this opportunity to persuade her to eat or take nourishment. If a patient will not take her regular meals, she must have nourishment every hour. Sometimes these cases will resist all efforts to be fed; then gavage must be resorted to. These patients use up so much energy that if a sufficient amount of nourishment is not taken they will become exhausted. When the excitement leaves, the patient is generally very weak and exhausted and will require very careful nursing to build her up.

Depression is another kind of mental condition that the nurse has to deal with. The student nurse must be taught from the first that all depressed patients have suicidal tendencies. Many of these cases are mildly depressed and are able to carry on with the help of a nurse. It is this type that the nurse will find the schedule very useful for. Some of these patients become very depressed, restless, and agitated. They are very difficult cases to nurse. Many of them become very suicidal. Suicide becomes almost an obsession with them. They think of nothing else. Very careful and tactful nursing is required, as the patient will resent being watched and the nurse will have to be constantly on the watch without appearing so. The patient becomes worried and feels that she is not trusted. This cannot be stressed too strongly to the student nurse. Very often the new and inexperienced student will forget or cannot see why the patient must be watched so closely, and may leave the patient to herself long enough for her to accomplish her aim. In extreme cases of depression, the patient will have to be kept in bed night and day, removed only when she will receive treatments. In most cases it is better to get the patient out of bed and try to get her interested and take her for walks in the fresh air. It is better to walk in the country and avoid the city and crowds, in case she should take an impulse and run and jump in front of a street car, etc.

The usual treatments for the nervous and mental cases are baths, massage, electrical treatments. Occupational therapy is very important. These patients are usually too depressed to read and it is rarely that the nurse can get the patient's attention to read to her. Patients suffering from depression usually have no appetite and resist food. Great care must be taken in the preparation of the food for this type. Make it as attractive as possible. Give a small amount of food at a time, but give it often. Try to cater to the patient's tastes. If solid food is refused, liquid nourishment must be given every hour or more often, as only an ounce or two may be taken at a time. In a case of this kind the intake of fluids

during the twenty-four hours should be at least 100 to 150 ounces. The nurse must keep an accurate record of all food taken by the patient. As insomnia is always present, the nurse must try to induce sleep without the use of drugs: try the tepid baths, hot wet packs, light massage, warm drinks. Remove any article of furniture which might irritate the patient. The nurse must be instructed not to leave the patient alone for one minute during the night or day.

All student nurses must be instructed early in their training that in caring for the nervous and mental cases they must not argue or contradict the patient. They must learn that the delusions and hallucinations are very real. In nursing the mental patient the main object is to see that she has plenty of rest and sleep, fresh air, and some exercise; that she takes plenty of nourishment to try and build her up physically. Many times, after she has been built up physically, the mental condition will improve. She must be kept occupied with occupational therapy, such as basketry, fancy-work, painting, etc. The nurse who hasn't had training or instruction in psychiatric nursing will find the nursing of these cases very difficult and almost impossible.

I regret to say that up to the present the mental nurse has not yet received her halo which her more august sister in general nursing has long since obtained, but I am convinced that the day will come when mental, or psychological nursing, as I prefer to call it, will become the blue ribbon of the profession.

(Elizabeth L. Macaulay, Matron, Kent County Mental Hospital, Maidstone, in an address before The British College of Nurses on October 16th, 1929. From The British Journal of Nursing, November, 1930.)

State Health Insurance

A Report on the Feasibility of the Introduction of a Contributory Health Insurance Scheme to the Province of Manitoba

By DR. E. S. MOORHEAD, Chairman, Welfare Supervision Board, Department of Health and Public Welfare, Winnipeg, Man.

It is impossible to enter on the subject of the application of Health Insurance to the Province of Manitoba, until we have made a short survey of the trend of social economics, and the remedial legislation which has been brought into being during the last few decades to mitigate the disabilities of those who work for a daily wage.

May I take you back to an early stage in English history, where you will find that much of the medical service was supplied by the monks, and hospital accommodation was provided in the monasteries.

We still have terms in medicine which show this influence, such as Friar's Balsam, Jesuit Bark from which quinine is obtained, and Monk's Hood or Aconite. St. Bartholomew's Hospital was founded in London by a monk in the year 1123. We then take a jump to the reign of King Henry the Eighth. The Crown seized the monasteries, ejected the monks, and organised medical service, as far as we know, ceased to exist. After a long period, three events took place which were associated with the beginning of a new economic system in England. A system which was to draw the inhabitants from purely agricultural pursuits.

These were the developments of industry; the migration from country to town, and the erection and endowment of hospitals.

In the past, and until quite recently, the daily wage earners were included in the penniless group when sickness, accident or old age overtook them. They were entirely dependent on private or voluntary charity, and it was almost obligatory

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on the wealthy to leave some form of endowment to assist their less fortunate brethren. When the sufferings of the poor became greater than the relief supplied by voluntary organisations, it was recognised that some form of official recognition must be taken, and some relief given. This was administered in a crude and unsympathetic manner by parish, municipal or county officials, who seemed to take pleasure in increasing the distress of the poor by pointing out the stigma attached to support at the expense of the tax-payer. Dickens in several of his books did much to force this point of view on the attention of England; and from that time, though the progress has been slow, a different outlook has arisen. During the last fifty years, it has come to be recognised that the man who has spent his life, or has become sick or injured in the service of the industry of his country, is entitled to something more than a haphazard charity or begrudged existence in a work or almshouse. When this was accepted it appeared that the State alone should be required to provide any comforts necessary, but by degrees it came to be acknowledged that such a scheme could not be carried on indefinitely, nor to the extremes which the socialist element demanded. It discouraged thrift, it cast an increasing burden on the tax-payer, and at a time when industrial output was diminishing, and huge expenditures had to be met, the state decided that benefits must be paid for, in part, by the recipient of them. It is at this period that we find plans brought forward whereby benefits were secured by a form of insurance; to which the insured, the employer and the State subscribed in varying proportions. These were the steps which led by slow degrees to the present state of affairs in social economics. It must be remembered that there is a marked difference in the application of the regulations to the different subscribers, depending on the political outlook of the party in power. On one side, we have the condition in Russia where all contributions are made by the employer as opposed to Roumania where the employee pays all the premiums. There remains that condition which we find in many of the newer countries, when the state or province assume the whole responsibility, and the employer and the employee make their contributions indirectly through general taxation. It would be wise to make a brief study of those systems which have proved to be most popular in the older countries, with a view to fitting them into the economic system of the younger countries. Take the system where the employer, the employee and the state contribute certain fixed sums per week; this presupposes several premises. First, that a large percentage of the population can be placed in the relative positions of employer and employee. While this holds good in highly industrialised communities, it is not at all applicable to this country. Here, we have the farmer, who for several months of the year may be quite independent, even to the extent of being an employer of labour; during the remainder he may be an employee working in a lumber camp or other winter occupation. Second, that a week's or a month's work will represent a definite sum which will be paid at regular periods and over a fixed number of months in the year. We have two difficulties—the farmer employer never knows until his crop is sold what his average weekly wage will be; in case of local or general disaster, the weekly wage may be non-existent; similarly, the employee of a farmer may fail to recover the wages which were promised to him owing to such misfortunes as hail, drought, or an unsold crop; further, while it has been possible in the past for actuarial departments to make an accurate estimate of the weeks of employment which may be expected by every working man, the world-wide

wave of unemployment has upset all these calculations, and countries are finding that the subscriptions of the employer and employee are much less than had been anticipated, and that the only form of adjustment which can be made, if the pledge made to the employee is to be kept, results in a larger share of the cost being shouldered by the state. Thirdly, the success of an insurance scheme presupposes a reasonable fixity of residence, or similar forms of administration in the different parts of the Dominion. Both of these are markedly absent in Canada. A fairly large percentage of the labouring population is not fixed in its habitation, but travels to whatever district offers for the time being hopes of profitable employment. For instance, we have the migration of harvesters from British Columbia, and eastern Canada to the west where the work is carried out by labourers over a period of six to twelve weeks, after which the migrants return to their own homes. Finally, there is the lack of uniformity in the legislation in the different provinces. There is not, and as far as one can see there is not likely to be, any similarity of regulations as it affects the various areas which compose the Dominion. If a man has acquired a status, and a province an obligation, by the fact that during a period of work the former has parted with a sum of money which is to be used for insuring him against disabilities, it is unreasonable that he should be penalised through moving to another province, though still living in the same country and under the same flag. Yet, that is exactly what would happen to him. To judge by the number of traffic laws, our legislators would appear to be cognisant of the fact that the world has taken to wheels, but they appear to be unaware of the fact that wheels which are functioning tend to reduce both time and space. I think we all agree that it is reasonable that the man who is given medical assistance and relief to carry him over a period of illness should subscribe to it during the period when he is able to work. We then have to ask ourselves, should the plan be put into practice as a voluntary or a compulsory system? Many countries have tried the voluntary system and failed. One alone, Denmark, has succeeded. It is difficult for us living in the West to appreciate the density of the agricultural population, and equally difficult to estimate the wonderful spirit of co-operation found there. Denmark is surrounded by thickly populated countries highly industrialised, where she finds a ready market for her produce; some years ago she was able to overcome her chief competitor, Ireland, in supplying eggs and butter to the English market. Denmark has something like 60 per cent. of her population of three and a half millions insured against illness by the voluntary system, but Manitoba has no reason to suppose that she can follow this example.

Let us now consider the compulsory system, first, as applied to the employee, and second, as it concerns the individual, be he farmer, watchmaker, small store-keeper, etc., who earns a small livelihood, while maintaining his independence. The latter may be just as much in need of medical assistance and subsistence during illness as the employee. How are you going to collect from him? You certainly cannot do it through the mails. If he pays no attention to the weekly notices sent him, are you going to put a lien or mortgage on his property, or will you hale him into court? The courts would soon be clogged by the numbers appearing for judgment. Are you going to employ collectors or inspectors, travelling over the immense districts which comprise the province of Manitoba? The cost of collection would probably be 50 to 75 per cent. of the money turned in, and no system of insurance could stand an overhead like that. In England, highly industrialised and thickly populated

as it is, where only employees are accepted, and where those employees are frequently to be found to the number of thousands in one establishment, the cost of collection and administration is 12½ per cent. How much more would it be for us with our population which is mainly agricultural and certainly wide-spread? To set up a system which would only include Winnipeg and other cities, and would be limited to employees is to approach the fringe of a difficult problem, and leave the main body untouched. Summed up as between a system of health insurance entirely supplied by the state, or one mainly provided by employer and employee and subsidised against emergencies by the state, the latter is the better. As between the compulsory and the voluntary, the advantage lies with the latter. In each case it does not appear to be possible to devise a collecting machine which will be efficient, moderate in cost, and able to overcome the physical difficulties found in the province of Manitoba. In leaving this angle of the question it seems appropriate to refer to the means which other countries have taken to solve somewhat similar difficulties, difficulties which are entirely due to physical causes. Three may be mentioned, the Highlands and Islands of Scotland; certain communities in the mountainous cantons of Switzerland, and South Africa. The National Health Insurance Act of Great Britain is operative legally over the whole of Scotland; but it is found that in certain sparsely populated districts where the inhabitants are poor, and not engaged in any steady industry, it would not be feasible to collect the weekly dues, and even if it were, no doctor could afford to work for the income provided, more especially when long distances and difficulties of transportation are taken into account. Therefore, the state induces doctors to settle in these areas by means of subsidies. The scale of fees to be charged by the doctor takes into consideration the poverty of the patient, but does not allow for the distance to be travelled. That is, the fee is based on the supposition that the doctor lives near to his patient. The state adds to the fees received a sufficient sum to bring the income to $2,500.00 per annum. Travelling allowance and house are also provided.

In some of the higher altitudes in Switzerland there are communities which are shut off from other towns to such an extent that they would be unable, on account of snow, etc., to procure a doctor at certain times of the year, and unable to pay him for the time and distance covered. In such cases, younger doctors are induced to abide for a time which is usually limited by the necessity of providing better education for growing children. The doctor is paid partly by a tax assessed on every member of the community, and partly by a state subsidy. In the thinly populated districts of South Africa instead of a direct subsidy the doctor's income from patients is increased by giving him official or state appointments such as health officer, sanitary inspector, coroner, etc., but the inducements to remain are not as a rule very great.

There are two difficulties which have developed in the working of the Acts to which I must draw your attention, for they may do a great deal to militate against the success of it. I will state a provisional case. A farmer develops an attack of bronchitis in December; the doctor sees him and satisfies himself that he has the disease, advises him to stay indoors, and gives him some cough medicine. At the end of the week the doctor is asked to send some more medicine, and the attack may easily be made to last six or eight weeks. It would come to an end promptly if the patient found some profitable occupation. Seeing, however, that he has no work to do, that he might as well be drawing sick pay, and that

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he always has a bit of winter cough, you can see his point of view. You cannot say that it is fraudulent, but you can appreciate how much it will add to the cost. The same condition may arise in any case where there is seasonal unemployment, or where owing to economic conditions a large number are out of work. The man who loafs at home with nothing to do and no prospect of getting work develops digestive troubles and various neurosis, which he considers entitle him to sick benefits. It is just this state of affairs which has caused a tremendous increase, about 100 per cent. during the last ten years, in the number of people who are receiving medical services and sick benefits in England. It is a condition for which we have to be prepared if we undertake a provincial health insurance scheme, similar to those in Europe. In my public ward service in the General Hospital there are numbers of adult men who on one plea or another endeavour to remain as bed patients during the worst months of the winter, but suddenly get rid of all their complaints as soon as milder weather brings a promise of employment.

Then there is the bottle habit, which also shows an alarming increase, and the custom of visiting the doctor for the weekly certificate and another bottle, adds heavily to the cost. There seem to be two reasons for this. A bottle of medicine in the kitchen or bedroom is an outward and visible proof of an illness, which might otherwise be questioned. Secondly, there is the feeling that one is getting something tangible in return for the money that has been paid. Some countries try to discourage the habit by requiring the patient to pay a definite percentage of the value of all medicines, etc., supplied to him.

It would add to the success of any method of State Health Insurance which might be introduced that it should be applicable to the whole province; in other words, that it should fit both the industrial worker and the farmer. Such a project would at once introduce a difficulty which at present seems insuperable. The industrial worker's outlook is based on a pay day which occurs every week or every fortnight. He bases his budget on an expenditure which has to be met and settled at regular intervals. His grocer, his butcher, etc., sell him goods on the understanding that he will not require credit for longer than two weeks. He frequently buys his winter supply of fuel by payments which are spread over the whole year. If he indulges in something expensive, or a luxury such as a car, a gramophone, etc., he takes possession on condition that he will make regular monthly payments. His pay is, therefore, definitely assigned in advance for either necessities or luxuries, with little or no leeway for any misfortune. To such a man, sickness of more than ten days duration is a disaster. His credit, which was good as long as he was working, at once ceases. He may lose possession of his car, etc., but, much more important, he and his family are lacking in the necessities of life. To this man, sick benefits must be combined with medical services. As opposed to this there is the farmer who might be said to have one big pay-day per annum. There will, of course, be smaller sums from time to time when he sells milk, eggs and butter, stock, etc., from the farm. He is supposed to clear up his obligations every fall, lay in whatever will be necessary during the winter, and arrange for his credit during the year. For this man sickness does not mean ejection for non-payment of his rent; he has probably food and fodder sufficient for his family and stock for some time; in many districts, he will have a good supply of fuel laid in for little more than the labour of getting it. The renewal of his clothing may have to be postponed. This man, when ill, is not nearly as much

in need of sick benefits as the industrial worker in the city. Another point which I had forgotten is that the members of a farming community are more neighbourly and more helpful to each other than are the shifting members of a city block. I do not say that sick benefits to the farmer would not be convenient and helpful, but he has not the same urgent need for regular payments as has the industrial worker.

Having discussed the question from the point of view of the sick man we must now turn to the outlook of the doctor, the druggist and the hospital. I am supposing that competent actuaries would deal with the amount of sickness that would ordinarily arise in the province, and that from this the amount of money necessary to provide the various services would be found. The hospital would certainly have to be reimbursed in case of a deficit, since no hospital could be allowed to close its doors for lack of funds. Doctors could be expected to undertake treatment on a whole-time or part-time basis, or on something like the panel system in England. The whole-time doctor, appointed by the state, drawing a fixed salary, entitled to a pension, as a civil servant subject only to dismissal for gross causes, while a success in institutions, is looked at askance by the civil community to whose houses he may be summoned for sickness. The liberty of personal choice has been removed; there seems to be to the patient a lack of sympathy in their misfortunes, and a lack of understanding of their difficulties. In place of a family friend and physician, they find a policeman who quarantines them for infectious disease, and an autocrat who announces that the sickness is over and that no more visits will be paid and no more benefits received. Requests for medical services at inconvenient times, or where no real illness exists leave a feeling of irritation on both sides which is not beneficial to the smooth working of the plan. A physician, especially one who has been in practise for himself, rather resents the interference of the state. There are unnecessary forms and reports to be made out; medical inspectors visit him from time to time, causing annoyance, and a disgruntled patient may put him to a great deal of inconvenience by sending a report to headquarters bureau. As against that, the security of tenure and salary, and the certainty of a pension, with a reasonable annual holiday do much to modify the various drawbacks. I do not think that this applies to the municipal doctor, but I shall deal with that later. The part-time doctor is little more than a makeshift. He is guaranteed certain gifts within the power of the state, accompanied by a certain salary, and he is expected to make the balance of his livelihood from the private patients whom he treats. This is not always satisfactory, because the income from private practice frequently turns out to be less than the estimate made by the state. In return for certain benefits the state requires him to look after poor people who cannot afford a fee; there is occasionally disagreement over the border line cases. It is characteristic of this type of appointment that it always appears to be more attractive at the time of application than it subsequently turns out to be. From the point of view of the doctor, this type of appointment has many drawbacks. He is not a civil servant. There is no security of tenure; he feels that if he works hard and makes a success of it, his subsidy may be reduced. Such practices are usually to be found in isolated districts where the amenities of social life are few, and the outlook for a wife and growing family disheartening.

National Health Insurance in England with its panel system is only suited to industrial areas or thickly populated rural areas. In a certain

locality there are, let us say, fifty doctors. Thirty-five of them announce that they are willing to take patients under the panel system. That means that the names of these doctors are put on a list, board, or panel. Let us suppose that there are in this area 50,000 people who come under this system by right of the fact that deductions are made from their wages for medical services and sick benefits. Everyone of this 50,000 must sign up with one of the thirty-five doctors, provided the latter are willing to take them. There are certain conditions. No doctor can have more than, I think, 2,000 names on his list. There will be some patients whom nobody wants, but as the doctors have to give medical service to all the insured, these are usually divided amongst them. The doctors in most cases are paid on a per capita basis, and not on work done. Patients are allowed the privilege of changing their doctor, but with certain restrictions. The state lays down what service is to be given, which consists mainly of such attendance as can be provided by a general practitioner. He would not be required to do major operations, or to attempt the duties of an eye and ear specialist, etc. There are several advantages. First, and most important, there is free choice on the part of patient and doctor. If a doctor is open to taking panel patients, then he probably wishes to get as big a list as possible, therefore there will always be the stimulus of doing his best work, in order that he may acquire a reputation which will induce patients to leave another doctor and come on his list. Finally, it is to the doctor's benefit to use every endeavour to prevent illness, seeing that his pay per head per annum is fixed, and that it is less trouble to look after a well than a sick man. There are, of course, complaints. The patients want the service of specialists when their illness is such as to require expert assistance. The doctors feel that the bureaucratic hand of the state is too much in evidence. Too many reports to be made; too many records to be filed; too much disciplinary action in case of large drug bills. On the whole, the system appears to work fairly well, and gives satisfaction to a large proportion of fifteen or sixteen million people. I mentioned in an earlier part of the report the fact that unemployment tended to increase the cost considerably. I should also have mentioned that the rural practitioner is allowed mileage. Even with this, as I pointed out, there are certain areas so sparsely populated that the panel system would not work. There emerge then the two great drawbacks to the panel system of health insurance as applied to Manitoba; the impossibility of collecting the regular dues from people who are not in steady employment under a corporation or owner; and the impossibility of giving satisfactory service over large areas, where the population is too small to support a doctor by its contribution.

There has been tried out of recent years a new method, namely, the municipal doctor, which seems able to adjust itself satisfactorily to conditions in the country. It is not necessary for me to go into details. Roughly, it consists of the payment of a doctor for all services by means of a land tax. The spirit of co-operation which is so necessary for all these plans, is further evident in the project by which municipalities are combining to maintain a hospital, and pay a competent surgeon and staff.

A provincial contributory system of health insurance does not appear to be feasible at present in Manitoba; it might be applied to the cities; it would be too expensive for the average country district; and the unorganised territories, far from contributing for medical service, will probably have to be helped out for some time by means of a state subsidy.

The Relief of Constipation

By Dr. A. S. MONRO, Member of the Consulting Staff, Vancouver General Hospital

I am here today as a result of a chance remark. A week ago, in discussing with the Director of Nursing the advantages that would accrue to the patient if the general direction and responsibility in the use of laxatives and general care of the bowels were in the hands of the nursing staff, she replied by asking me to address you on this subject.

Modern medical research has clearly incriminated the colon as a source of more disease and physical suffering than any other organ of the body. The condition referred to is chronic colonic stasis. Artificial conditions of civilized life, sedentary habits, concentrated food stuffs, false modesty, ignorance and neglect of bodily needs have produced a crippled state of the colon as an almost universal condition among civilized men and women. Intestinal toxaemia or auto-intoxication is the most universal of all maladies, and the source of auto-intoxication is the colon, with its seething mass of food residues. In a perfectly functioning intestinal tract three bowel movements a day is normal. The infants and children of today are much better trained in this respect than those of the older generation. It is not uncommon to find children, who, as a result of proper training from infancy, have more than one bowel movement a day.

The food residue reaches the colon in eight hours, and in doing so traverses about twenty-five feet of intestines. It is now within about three feet of the lower outlet, and one would naturally suppose that an additional three or four hours would suffice to complete its passage through the intestinal tract. However, this is not so in the ordinary individual whose habit is one bowel movement a day. In such an individual the passage through the colon is of much longer duration. It has been estimated that the final passage of food residue in such a person takes forty hours, or twenty times longer than it should.

My attention was first directed to this subject about the close of the war. We had in the Military Annex some three hundred soldiers, many of them having been bed patients for months or even years. The old methods of relieving the bowels were found to be entirely inadequate. The dietitian worked out a very excellent laxative diet, and this, supplemented by the use of liquid petrolatum, gave excellent results, and the patients were grateful for the improvement brought about by their use. The treatment, then, of chronic colonic stasis, in the vast majority of cases, consists in the use of *bulk* in the *diet* and *lubrication*.

In the course of the past ten years I have paid particular attention to this matter in my private practice. Seventy-five per cent. of adults suffer from some degree of colonic stasis. To these I have outlined the principles governing the correction of this ailment and have embodied them in a short list of directions which I hand each one that requires it. If the individual who receives these directions will carry them out faithfully and systematically, he will, in a short time, commence to benefit from them, and in the course of a few weeks or it may be months will be relieved from the necessity of taking medicine in any form whatever. The improvement in general health that will follow will be most gratifying, and it is seldom that, after having once achieved success in this matter, they will allow themselves to relapse into their former habits. To save time I will read the directions:

(A ten-minute address given to the staff nurses at the weekly staff conference, Vancouver General Hospital, November 11th, 1930.)

Dietetic and Other Directions for the Relief of Constipation

1. **Drink More Water:** Commence the day by taking two glasses, preferably hot, before breakfast, and repeat this again before lunch and dinner. If the use of liquid petrolatum or similar laxative is necessary, a good plan is to take it in a bowl of warm water first thing in the morning. Follow the drinking of the water in the morning by taking twenty bending exercises.

2. **Use More Roughage in the Diet:** e.g., Dina-mite, and use bran freely with every meal. Spread it on the porridge, mix it with soup—put it on meat and potatoes—take it by itself—mix with water or milk.

Use white bread sparingly; use brown bread—whole wheat bread—bran bread. Take raw or cooked fruit with each meal. Prunes in the morning—raw apples at noon—a couple of figs at bedtime.

3. **Enema:** Should the bowels not move by bedtime, take a simple soapsud enema. This can be done very easily and without any undue trouble before retiring.

4. **Habit:** The bowels are amenable to routine and nothing is better than to form a regular habit of moving the bowels at the same time every day.

5. **Exercises:** In addition to the bending exercises taken first thing in the morning, nothing is more beneficial than a good walk. Avoid riding whenever you can and walk instead.

Massage: A great many obstinate cases are materially assisted by massage of the colon, which can be carried out by using a ball and rolling it from the right iliac region upwards, across, and down left side of the abdomen.

6. **Do Not Allow Any Day to Pass Without Having Moved the Bowels:** Persistence in this line of treatment will bring about a regular movement of the bowels—gradual elimination of the necessity of using an enema. The amount of petrolatum can be cut down, and finally the bowels should move regularly by the simple use of plenty of water and proper diet.

7. A very useful alternative to use with the liquid petrolatum is a fruit laxative, which is made as follows: Take one pound each of figs, prunes, dates, and raisins, to which add two ounces of senna leaves. Remove stones from the prunes and dates. Mix well and put through a meat chopper. Cut into suitable sizes and cover with piece of waxed lunch paper if desired and take one after each meal.

I may say that for years I myself have used a very excellent combination every morning for breakfast. It consists of a little "Dina-mite," which is cooked and served hot. This is covered with whole krumbled bran, and to this is added some fruit, whatever may be in season; berries in summer time; baked apples, stewed prunes, etc., in winter time. Over all is poured cream or milk and the whole mass mixed together. This is a very palatable dish and contains a large amount of roughage, and in most instances is all that one requires. To make the use of roughage easy at the family table, I have recommended that bran be placed on it at every meal, to be used in any way the individual may elect. Another excellent laxative is whole linseed. Four or five teaspoonfuls of this taken at the close of a meal and washed down with water or other beverage, is a very excellent form of roughage.

I have been asked the question, what do I do in post-operative cases? My plan varies according to the operation. After an abdominal case I generally use a double one, two, three enema as soon as it is required. Then as soon as the patient can take it, liquid petrolatum is given in hot water, p.r.n., until the bowels move naturally. It may be necessary, before this has occurred, to again order another enema. It case of hemorrhoids, I have years ago discarded the use of the tube. It is only a source of aggravation and annoyance to the patient. As soon as he is able after the operation, petrolatum is given in hot water several times a day until a bowel movement occurs. Very early also the use of a bulk diet is ordered and this, with the continued use of petrolatum, will enable the patient to have normal movements without the use of an enema within a few days.

In conclusion, I would impress upon each one of you that you give this subject your earnest consideration, and if any of you suffer from this disorder, practise this line of treatment on yourself so that, having fully mastered its possibilities, you will be able to pass it on to your patients.

Note re "Dina-mite": This is a laxative put up by a local company. It is composed of whole wheat, crushed linseed, and bran.

Department of Nursing Education

National Convener of Publication Committee, Nursing Education Section,
Miss ANNIE LAWRIE, Royal Alexandra Hospital, Edmonton, Alta.

How Public Health Nursing Can be Taught in a Hospital

The rapid development of nursing in the social direction is a challenge to those concerned in the teaching of student nurses, as they must teach them not only to minister to the sick, but to function as an educative influence on the future health of the patient. This, of course, introduces a new phase of teaching, which calls for organization:

1. Who is to be the agent on the ward for such teaching?

2. What new considerations will be necessary in the mental training of the student to prepare her for her added responsibility?

The solution of the first problem—the selection of the agent—is an extremely difficult one under existing hospital conditions. It is agreed that the responsibilities of the charge-nurse of today are already many and great, and they do not permit her to undertake a work of such importance. Is it not necessary, then, to consider the placing of this work in the hands of a ward instructor, who would be free to give her undivided attention to it? May I suggest the qualifications of such an instructor? She should have a wide knowledge of all branches of nursing, including public health, with the ability and desire to teach. She should be a woman of vision, stimulating in character, and she should also be well endowed with an interest in humanity.

Before discussing the duties of such an instructor, may I turn your attention to the student, the instructor's teaching material? Let us assume that she has been withheld from this branch of training until her probation term has passed, during which time she has been carefully moulded in the preparation for her advanced work. This brings us to our second problem—the new considerations that will be necessary in the mental training of this probation period. I would enumerate them as follows:

1. More emphasis on the study of anatomy and physiology.

2. An introduction of the elements of psychology.

3. A greater knowledge of elementary cooking.

4. A simple and an inspiring survey of the activities of the public health field.

Throughout the study of these, and all the other subjects of the probation term, it will be necessary to have the instructor emphasize to the student her opportunities for "passing on" health knowledge to her patient. Perseverance in this on the part of the instructor will result in creating the health-teaching habit in the nurse, the very crux of our aim.

Let us now picture the duties of the ward instructor in relation to the student nurse: A patient has been admitted; diagnosed, suspect tuberculosis. His medical and social history and x-ray accompany him. The student nurse to whose care he has been allotted is instructed to read the history and to note the following points: heredity, housing conditions (whether crowded, properly ventilated, sanitary, and if sunshine is admitted), the type of diet, type of occupation, habits of living, and the present condition of his health as shown by his age, weight, cough, appetite, appearance and mental attitude.

The nurse, having the knowledge which explains his admission, can now approach the patient with a sympathetic interest which will make it easy to win his confidence. This once gained, the nurse, throughout her care, must take every opportunity to demonstrate, directly or indirectly, the health laws most applicable to his condition. She will have many chances during the day to do this if she is alert. For example, incidental explanation of any of the following:

Why a bath is given.

The necessity of a clean mouth.

The value of the hospital diet ordered.

Teaching the danger of having infected food and milk in the home.

The importance of water drinking.

The value of regular habits in the elimination of body wastes.

The reason for the care of infected material from the body, such as sputum, pus from wounds, etc.

The danger of dust as a germ carrier.

The meaning of the sterilization of dishes or of any articles that have come in contact with infected material.

The beneficial effect of the direct rays of the sun on the human body; its power to destroy the tuberculosis germ.

The value of rest and sleep.

The importance of mental health; how it can influence the proper functioning of the body.

A record of such teaching should be kept by the instructor, who throughout must guide and stimulate the efforts of the student nurse to sound achievement. K. P.

Refresher Course, University of Toronto—Nov. 17 to 22, 1930

By WINNIE L. CHUTE, Instructor, Brantford General Hospital.

A request from the Registered Nurses Association of Ontario for a Refresher Course for supervisors and instructors resulted in the Department of Public Health, University of Toronto, arranging and carrying out such a course with marked success.

It was not an easy task to arrange this programme as refresher courses had been held for two groups of nurses during 1930. The problem confronting the Department was to give this group what it needed without duplicating former programmes. This had to be done without calling upon departments in the University from which had been drawn lecturers for previous courses, or groups in hospitals in Toronto which had helped with the former programmes.

The following is a brief outline of the time-table as it was carried out:

A series of six one-hour talks on teaching methods was given by Mr. T. Mustard, of the Toronto Normal School. The effect of a carefully planned, well-presented lecture was so noticeable on a group of students under Mr. Mustard that one could appreciate the influence this would have on the learning powers of student nurses.

For a superintendent of an active hospital to give practically half of each day to a series of talks on Hospital Administration was the contribution given by Miss E. M. McKee, Superintendent of the Brantford General Hospital. Miss McKee spoke on the administration of a small hospital.

Miss E. MacPherson Dickson, of Toronto Hospital for Consumptives, conducted two round-table talks on the application of business law to hospital management.

Under the title, The School for Nurses, round tables were held on these subjects: Some Phases of Training School Administration, conducted by Miss Jean Gunn, of Toronto General Hospital; The Teaching of Nursing Procedures, conducted by Miss Beatrice Ellis, Toronto Western Hospital; and Training School Records and Case Studies, also conducted by Miss Gunn.

Miss Ethel Johns, Director of Studies of the Committee on Nursing Organisation of New York Hospital, gave three thought-provoking talks on The Head Nurse of the Past, of the Present, and of the Future.

Visits were made to the Toronto General, Sick Children's and Toronto Western Hospitals, where various procedures were demonstrated by doctors and nurses, and a Tea was held in the Edith Cavell Home, Toronto Western Hospital.

Centralised Lecture Committee, Toronto, Forms Instructors' Section

An Instructors' Section of the Centralised Lecture Committee for Student Nurses has been formed, the object being to endeavour to have a group meet, all of whom are interested in the discussion of problems common to Instructors of Student Nurses, both Practical and Theoretical.

The first meeting of this Section was held in the Edith Cavell Residence, Toronto Western Hospital, on October 13th, 1930, when plans were formed for the coming year. It was decided that meetings would be held monthly, each hospital, in turn, being responsible for the programme.

On November 6th the Isolation Hospital provided, in addition to a tour of inspection, interesting clinics on Scarlet Fever and Diphtheria, where Tracheotomy has been necessary. At this meeting eighteen members were enrolled, including instructors and others doing part-time teaching.

The Women's College Hospital was responsible for the December meeting, held in the Residence on December 4th. A demonstration on catheterization and also methods of sterilizing intravenous solutions was carried out, after which the group was asked to discuss the procedures and offer solutions. Free discussion followed, all feeling that a better understanding of the procedures adopted by the various schools would be obtained.

The January meeting is being held at the Toronto General Hospital.

St. Joseph's Hospital Nurses' Home, Victoria, B.C.

By EDITH FRANKS, Victoria, B.C.

Completion of the new Nurses Home of St. Joseph's Hospital marks another milestone in the development of an institution that has been of outstanding service in Victoria for many years. It also sets a standard for nurses' homes in the Province.

It was the dream and ambition of Sister Mary Anna, Superintendent of Nurses at St. Joseph's for many years, to build a home that would provide adequate living quarters for the student nurses, and also class rooms, demonstration rooms, and laboratories for their instruction and training. She passed on with her desire unfulfilled. Such women are an incentive to those who follow after, and the Sisters who succeeded her took up the torch; worked and planned with the vision of a new nurses' home ever before them. Through the untiring efforts of Sister Mary Mildred, Superior, and Sister Mary Gregory, Superintendent of Nurses, the vision became a tangible reality, and the result is a modern three-story building, surrounded by natural beauties unsurpassed in any other part of Canada.

The entrance suggests the atmosphere of dignity and charm that pervades the home in all its appointments. To the right is a spacious living room, with a huge fireplace at one end opposite the door. The beamed ceiling and polished floors give an air of solidity, while the pretty rugs, tasteful draperies, cosy chairs and deep couches add luxury to the beautiful room. The room was furnished by the Hon. Randolph Bruce, Lieutenant-Governor of B.C.

On this floor, besides the suite of rooms for the Superintendent of Nurses, there is the bright sunny room facing west, containing a fiction and reference library, an infirmary containing two beds and a bath room ensuite, for convalescing nurses or for those who may be ill, but not ill enough to be sent to hospital. Opposite to this is a diet kitchen, fully equipped, where the nurses may make tea or evening refreshments.

The Lecture Hall has its platform or stage on this floor, and a few steps lead down to the lecture hall proper, which is a very commodious room 42 feet by 60 feet. It has a splendid dancing floor, will accommodate very large card parties, and it is intended to have a stage curtain so that the room may be used for private theatricals and other forms of entertainment.

The bedrooms on each floor are well lighted and amply supplied with closet space. Some are double, some single. The double ones have two clothes closets so that the clothing of each nurse may be kept separately. On the third floor ten rooms are shut off with double doors to ensure quietness for the night nurses. On the second and third floors there are little sitting rooms, tastefully furnished, where the nurses may go to rest or to study. Telephones are supplied on each floor.

In the basement, or ground floor, there is a very spacious demonstration room and class room equipped with every modern device for teaching all the branches of nursing science. Leading out of this is a chemical laboratory, equipped by the Alumnae of St. Joseph's Hospital. This is surely the last word in laboratories. On the same floor is a diet kitchen where cookery is taught and diet in disease is studied.

Other conveniences that tend to make up a modern, well-equipped nurses' home are an incinerator with a chute from each floor; an ample trunk room; and a hand laundry equipped with set tubs, hot and cold water, ironing boards, electric irons, and a drying room, where the nurses may wash and iron their "undies" and dainty things that cannot be sent to the laundry.

Nothing seems to have been forgotten or neglected that might add to the comfort or convenience of the pupil nurses. The air of refinement and dignity that pervades the whole place in all its appointments make it a fitting place for our young girls to live. We feel that here they live in a cultural atmosphere, that tends to develop ease of manner, a happy, quiet, lady-like demeanour and the effacement of self by following the example of the Sisters of St. Ann.

Department of Private Duty Nursing

National Convener of Publication Committee, Private Duty Section,
Miss CLARA BROWN, 153 Bedford Road, Toronto, Ont.

From a Private Duty Nurse's Diary

"Miss T., will you take a country case for Dr. B. of R——? A case of bronchitis with a heart condition. You will be met at T——. The train leaves Halifax at 2.30 p.m." R—— is a beautiful, tiny fishing village on the south shore of Nova Scotia.

As it was nearly train time when called, I hastily packed a bag for a country case—besides plenty of uniforms and nursing articles, one must be sure to put in a very heavy dressing gown, as besides getting up many times in the cold night, one nearly always is glad of an extra bed covering.

After a very pleasant train ride along the seaside, I arrived at M——, where we changed to an electric train for T——. It was quite dark when we arrived at T——, a lonely station. After waiting a moment or two a young man came up. "Are you the nurse for Dr. B?" I replied in the affirmative and was led to a Ford car and, with many packages, was settled in the back seat. The young man and a friend got in. Away we went in the darkness, driving it seemed, endlessly, on a rough road, and such curves! One took a deep breath and wondered if we surely would not go over on the next one. However, at the end of an hour we arrived at a small country house. I was led up a narrow, almost perpendicular stair to meet Mr. D——, the patient.

I found I was to be on duty twenty-four hours and sleep on a cot in the patient's room, and wash and dress in an adjoining room. Everyone visiting the patient came through this room. One day I had a narrow escape as the minister came through without knocking just as I finished dressing.

The heating was by a coal kitchen stove and a base burner. Very little heat came upstairs. There was a tiny wood stove in the patient's room (the nurse carried up the wood) but it smoked badly and was used only when absolutely necessary. After central heating and baths, trying to keep warm and washing in very little water in a hand basin proved hardships.

The people, very unusual in that part of the country, were poor managers. Only a kettle was used for heating the water and there was very little in it at any time. There was plenty of food, but I had to choke my "feelings" before using cutlery or dishes.

The patient was to have continuous hot linseed poultices during the night. I changed them frequently until he slept easily toward morning. It was cold going downstairs to make them. Early the next morning I went down. It was so cold. The base burner had gone out and my patient's wife was struggling with porridge on the kitchen stove, in which the fire refused to burn. I sat shivering until nine o'clock when hot porridge and tea warmed me up. I found my patient always slept until 10

o'clock so in future I didn't get down so early.

There were two windows in our room. One of them was blanketed over. It was at the foot of the patient's bed and the head of my cot. When a day or two later I cautiously took the blankets down I discovered it was a south window from which was being shut out a wonderful sunshine. It was with great difficulty I persuaded the patient to let me open a window and let in the glorious sea air. He progressed splendidly for about a week and then seemed to get a fresh cold, which of course was from "opening the window." They never opened a window during the winter.

These people were unable to afford a nurse so at the end of two weeks, as the patient had improved considerably, I was able to leave. He could not see why he should pay my travelling expenses: "nurses ought to be so glad to get a country case they should gladly pay their own travelling expenses."—Mid-winter in Nova Scotia.

Of course there were compensations. The people were very kind and appreciative; excepting the patient. He was trying at times, but as he had been in bed off and on for about a year, and had been a strong fisherman, one could imagine his resentment at such confinement.

It was a beautiful country. I always took time off for walks when possible, as otherwise I should have been quite useless. The fresh crispness of the air, the salt tang and the sunsets made one almost willing to pay one's travelling expenses—but I didn't tell the patient so.—J.T.

Sunlight at School

ROBERT FORGAN, M.D.

While doctors, industrialists and farmers have been realising the value of artificial sunlight, it cannot be said that our health authorities have been utilising it to the full. It is true that the Ministry of Health wishes to see the use of sun-rays widely extended; but it is for the Local Authorities, the Borough Councils, to make the first move in the matter. The benefits of fresh air and sunlight are recognised by education authorities when they provide open-air schools for children who are physically and mentally defective; and these schools are so successful that the attendance at them is actually better than the attendance of normal children at ordinary schools.

A Plea for the Health Child

I was greatly impressed by the report of a Scottish school medical officer who, some years ago, recommended that, on the few fine sunny days in winter time, the ordinary schools should be closed, and the children sent to play in the sunshine. This, he declared, would benefit not only the health but also the educational progress of the pupils. It certainly does seem absurd that we should reserve the benefits of open-air schools for the delicate and backward children, and that artificial sunlight should be employed by school medical authorities merely to restore health instead of to prevent disease. The development of nursery schools for the younger children will, we trust, provide both natural and artificial sunlight for the toddlers whose health nowadays is so often marred before they reach school age.

(From Sunlight (Eng.), Vol. 2, No. 1.)

Department of Public Health Nursing

National Convener of Publication Committee, Public Health Section.

Records: Their Value in Public Health Nursing

By N. EMILY MOHR, Toronto, Ont.

Most workers in the social and health fields keep records of some kind, if for no other reason than to supply certain simple statistics either to the municipality, the government or a voluntary board. These records have usually been kept on a card on which is printed the subjects on which information is required with perhaps a few lines left for remarks. Gradually we are coming to see that if we have records at all they should be made adequate and complete so that the information recorded may be of real and permanent value.

I shall introduce this subject on Records under three main heads, as follows:

1. Why records at all.
2. If records, what form should they take.
3. The writing of records.

1. *Why Records at all.*

We hear objections to keeping records expressed mainly in terms of the time factor involved, the space they take up over long periods of years, the clerical assistance they frequently involve and the expense of installing records, filing cabinets and extra office space required. These are objections worthy of consideration for unless the results achieved by the keeping of records are worth while there is no justification for them.

What are the aspects then that make the keeping of records worth while? First there is the accurate information which is obtained in this way and *recorded* so that anything in regard to a patient may not be dependent on a nurse's memory or on the nurse's actual presence. There are workers in the public health nursing field as in others who have excellent memories, but it is well known that even the best memories are influenced by psychological factors, coloured by personal reactions and influenced by later developments. Also workers (even nurses) become ill or go on leave of absence, get married or die, and frequently the valuable information which they carry around in their heads, is lost to their successor or to others having a legitimate interest in the welfare of the patient.

Then the value of records as a means of refreshing one's own memory, critically checking up one's own work with the patient or his family, getting the facts clear and before seeing or visiting the patient again making mental notes of those things which are missing for a complete history of the case, is considerable. This practise of re-reading one's own records also has a value in raising the standard of one's own work. If we approach our work in a spirit of self-criticism and open-mindedness we will make the greatest possible use of our records for this purpose.

Another aspect of records we ought to consider is that of passing on information. It is sometimes necessary for a new nurse to take over a clinic or a school or the visiting in a dis-

(A paper given by Miss N. Emily Mohr, Director, Social Service Exchange, Toronto, at a Round Table Conference on Records Refresher Course for Public Health Nurses, University of Toronto, April, 1930.)

Institute of Public Health
Faculty of Public Health
University of Western Ont.
London

trict, as a temporary arrangement. Unless records are kept and unless these are very complete and accurate, the patient will suffer unnecessarily through lack of knowledge and intelligent understanding on the part of the new nurse. The same is true when a nurse is permanently replaced. Then too, you may be doing a specialised piece of work with a patient and six months after discharge another nurse under different auspices, may be called on to give another type of service. She will want to understand the patient's past illnesses and physical history, and so the record becomes valuable for reference saving the patient needless questioning or the verifying of statements made.

Finally, records are valuable as sources of information in making studies or in research work. Lately we have heard a good deal about the high maternal mortality rate. Certain theories may be advanced in regard to this condition, but if we wish to make a study of say 500 cases in different parts of the province in order to arrive at the actual causes and factors present, must we not turn to records for our facts, and if there are no records or if the records are inadequate can we arrive at any worth while conclusions?

We can, I think, proceed with the assumption that records are not only desirable but that they are essential to the welfare of the patient, to good work on the part of the nurse, and to analysis and study for purposes of improving methods and broadening the field of social usefulness. Do these uses justify the time records involve, the space they require and the expense incurred?

2. *If Records, What Form Should They Take?*

In the field of welfare, as in the field of medical practice, we have become rather highly specialised, and we have today, particularly in our large centres of population, a widely varied field of social endeavour in behalf of the individual suffering from some social or health maladjustment. We have Social Case Work in all its various branches, Family Care, Child Care and Protection, Child Placing, Behaviour and Delinquency, Care of Homeless Men, Community Centres, Settlements, and Social Research. In the field of Community Health we have various branches also, dealing with such specialised things as Maternity Care, Health Education both in the home and the school, Infant and Child Welfare or Child Hygiene, Communicable Diseases, Hospital Clinic Work, Industrial Welfare, and Psychiatric Social Work (although this latter is not restricted to the nursing profession).

Records being one of the necessary tools in our welfare programme, no matter what particular aspect we are interested in, the tool naturally must vary to fit the particular task with which we are concerned. The kind of record used by an organisation concerned with the Care and Protection of Children will be very different from that used by one concerned with the welfare of Homeless Men and these again will differ widely from the kind of record used by a nurse doing health work in the schools. The record necessary for a complete history of a Maternity Welfare Case will be very different from that required for a psychiatric case. The emphasis is on different things. At the same time are there, perhaps, certain general principles which may be arrived at regarding the kinds of records used?

As a general rule there are three parts to a record: first, forms to be filled in, such as will make quickly available permanent facts likely to be needed for reference (usually printed and depending on the character of the service being supplied);

second, general recording of facts obtained or observed regarding the patient (a current record usually); and third, documents such as doctor's reports, signed agreements regarding examination or the administering of an anaesthetic, correspondence, etc. Should these parts be kept together or filed separately? If kept together what is the best medium? Should records be kept on cards or on sheets? If on cards, what size of card is best? And are cards as adaptable to extensions of the record over a period of years as some other form would be? If a sheet type of record is used and the various parts mentioned above are to be kept together, what is the best medium for doing this? Is it the open folder? In considering these questions we have to think in terms not only of cost and space but also in terms of quick reference and adequate recording. In the filing of records bulk is a real problem, and although that may not be a serious matter when there is a small clientele, the question arises whether we are ever justified in installing a system of records and files which in later years will have to be scrapped.

Another question is that of keeping an index to one's files. Is an index always necessary or when does it become necessary? If you have a Central Index in your community (commonly called a Social Service Exchange) is an index of your own still desirable?

In considering what form your records should take, ask yourself also whether or not the particular work being done is of a temporary or experimental nature only, or is it permanent? You may be making a health survey of a school population. Will the records kept be the same as those kept for the permanent regular work of health supervisor in the community, including that of all school children? Again, is the work you are engaged in something of a fairly limited character, as for instance the health supervisor of a small factory personnel where the nurse is responsible only for accident work? Should the record for work of this kind be the same as that of a district nurse concerned with the health of family groups, housing conditions, sleeping arrangements and health education, or the work of an industrial nurse involving health education and family adjustments?

A great many considerations enter into the whole question of the form a record should take, and a thorough discussion of these considerations should help us in making our decisions. To use a certain form of record just because someone else uses it may lead us nowhere, really. On the other hand, would it be an advantage to have a uniform type of record which might be adaptable to various organisations doing similar types of work?

In deciding on the kind of record to be used the points to be kept in mind are:

(1) The adequacy of the record from the point of view of a thorough and complete understanding of the patient's condition, and from the point of view also of your own organisation, what your field of service is, and what your community responsibility is.

(2) Easy reference both for purposes of refreshing one's memory and for possible improvement of method.

(3) Growth or expansions in the field of service.

3. *The Writing of Records.*

Keeping in mind the *reasons for having* records at all, namely, accurate information regarding the patient; a complete picture of the case with opportunities of refreshing one's memory and as a basis for plans of action or changes in plans: the passing on of information to others concerned; and the supplying of facts for purposes of research or special studies; what are the factors which enter into the *writing* of the records?

Let us consider the material required in our records. We will sup-

pose that there is some kind of printed form to be filled in containing those permanent facts needed for ready reference. This is commonly called a face card or face sheet. It will contain such things as name of patient, date of birth (year at least —not just age), birthplace, present and past addresses and room for subsequent addresses, with date for each, status, religion where that is required, names and date of birth of other members of immediate family, names and addresses of near relatives with kinship stated. These are the identifying data. Then there may be other permanent facts such as physical defects, mental defects, occupation, education, etc.

In addition to the face sheet, there may be a medical sheet or card. In certain social agencies such, for instance, as those giving care and protection to children, where a routine physical examination is made, a special medical sheet is generally used with printed headings, etc. In family case work, on the other hand, this is not usually considered necessary, the health situation being generally recorded in the body of the general record. In a piece of work where the main concern is the health of the individual or where health supervision is a primary responsibility, a medical or health sheet would seem to be essential for ready reference and quick review. Can this sheet (or card), combined with or added to the face sheet, constitute the whole record? If so, then there is no opportunity of recording the changing environment of the patient, his attitudes towards treatment or towards education in hygiene, his reactions, and the descriptions, comparisons and relations which are necessary to a complete understanding of the whole case. Nor is there any opportunity of recording plans of treatment, action taken, and changes in plans on the part of the organisation or the individual nurse. Are these things as important as the face card information or the medical sheet? Are we convinced of their usefulness in a complete record of the patients?

Now the mere filling in of forms is hardly writing a record, and yet this apparently simple procedure should be done with great care. Why should a nurse put "measles" after "physical defects," and yet records frequently show just such things. The filling in of *dates*, too, is extremely important, and yet record after record omits these. The writing of a record is something we have to learn; it is part of our technical equipment, and in the work of a public health or welfare nurse, is coming to be considered just as important as other technical requirements now taken for granted. Like other technique it is not something which can be learned entirely from a text-book but must be learned to a large extent by doing. The text-books for record writing are records themselves. Two general principles should be kept in mind: first, that facts only should be recorded, and second, that only things relevant to the particular case should be recorded. Is there any value in putting down your own opinion in regard to any aspect of the case, or recording an impression or generalised statement?

Is there any value either in the writing into the record of something having no bearing on the case itself? Perhaps the commonest form of this is the tendency to put in things which really belong to an office record or day book. Such entries as "Called, no one at home" or "Called, could not get in," have no value whatever. Remember always that the purpose of the record is to interpret your patient, not to show how busy you yourself are. If you call at a home and there is nothing to record, then don't record it.

The current part of a record giving such things as a description of the patient's environment, the neighbourhood he lives in, the conditions surrounding his work, his personality (facts, not opinions or impressions), his attitude, his reactions and the development of the case, plans agreed upon, etc., takes usually the narrative form, and may be entered either in chronological form or in block form, depending on the type of work done and the kind of record you desire. A common form is the chronological one, making the entry under the dates when action takes place. These may be entered immediately, or within a week's time, provided that in the latter case careful notes are kept so that one may not have to depend on one's memory which is so often influenced by subsequent events, or unconscious prejudices. In a case where visits are being made daily or two or three times a week, these may be combined in one entry summarising whatever facts or occurrences need to be recorded.

For this narrative part of a record, a development, really, of our old friend "Remarks," should there be printed headings? If printed headings, will the records become too stereotyped, and will the nurse leave out some time something which may be of very great significance in a later development of the case just because there was no heading for that particular thing? Is it better to allow for individuality in the writing of this current part of the record? And if so, how can such a method be guarded from becoming a hodge podge with no logical sequence or a narrow and limited affair with no means of seeing one particular aspect of the case in relation to the whole?

A general outline of the things one should be on the look-out for will probably be of great assistance. The nurse then, before interviewing the patient or visiting the home, will have in her mind certain things on which she will seek to obtain information. These act as a guide, not as things to be strictly adhered to, and often of course, in cases of severe illness of the patient or other adverse circumstances, cannot be acted upon until these conditions change. In writing the record it is usually good practice to describe in the beginning how the patient came to the attention of your organisation and the reasons for his coming. Continue with a description of what the patient says in regard to himself. Then, probably, a paragraph on the type of work the patient is doing and the conditions of his work. There will be entries on the medical sheet regarding the doctor's examination and the record will contain such facts as the advice given by the doctor, comments by the doctor, etc. When a visit to the home of the patient is made, an entry under that date would probably give a description of the type of neighbourhood, the house and furnishings, the income of the family and the rent paid, the number of people living in the house, sanitation, ventilation, sleeping accommodation, with some personal history of the patient so that a picture may be given of the patient in his or her own environment. Other facts relevant to the case will be recorded also.

Marginal headings or captions will give the subject of each main paragraph so that quick and easy access may be had to any particular aspect of the case you wish to review. These also show you the gaps in your history which later on you can fill in. This procedure in record writing allows for great elasticity, for checking up one's own work and thus improving one's methods, for better supervision of the individual nurse (where there is a large staff), and most important of all, for a more intelligent service to the patient.

Where a record becomes lengthy some form of periodic summary should be used, again probably under

headings, the material for the summary being gathered from the record as made from day to day. You may have, of course, two or three summaries, as a medical, psychiatric and social summary, or you may combine all in one general summary.

If you have a running record of each of your cases, you can from time to time evaluate your work—see your successes as well as your failures and know whether or not you are following along the right line or attending to all the various aspects of your case. It is surely the responsibility of every nurse in the public health and welfare field, whether giving bedside care, clinic or district service, psychiatric service, industrial welfare or health supervision, to see that the patient has the best that it is possible to give; the best advice, the best technical care, the best personal service for which she is equipped. A carefully kept and properly written record is a tool in the process which like all other tools will be valuable or not according to the efficiency with which it is used.

Some means of preserving records (once they are written) is also a problem to be worked out, and in considering this I think the great question is, "Can we afford to consign our records to oblivion?" This in itself would carry us in to another long discussion on methods of filing and index systems, and other considerations which although extremely important to the subject of Records, cannot be entered into this morning.

Here we return to the point from which we started, namely, is this machinery of records and record keeping a justifiable expenditure of time and money and thought and if justifiable, what makes it so?

In summing up this discussion of Records it seems to me that the two main reasons for keeping records are:

(a) As a tool in the process of one's work.

(b) As a basis for comparison and research at a later period.

If you as nurses are fully alive to the value of this tool you will be able to persuade your organisation, your board or committee or whoever is responsible, of that value, and you will in the end refuse to work without it, both for the sake of your professional standards and for the sake of your patients and the community in which both we and the patients live.

BACK COPIES WANTED

In the November, 1930, number of "The Canadian Nurse" a request was made for back copies of the journal to be sent to the International Council of Nurses, to complete their collection.

In addition to about three-quarters of the missing copies, which have been supplied by the National Office, we have received a number from subscribers, but still require the following:

1916—February, March, April, June.
1917—January, February, April, May, June, July, September.
1918—September.
1923—April.
1930—February.

Anyone willing to donate or sell one or more of the copies required is requested to communicate at an early date to, Canadian Nurses Association, 511 Boyd Building, Winnipeg.

News Notes

ALBERTA

MUNICIPAL HOSPITAL, GRANDE PRAIRIE: Miss Ruth Hillborn (Misericordia Hospital, Edmonton, Alta., 1929), has joined the permanent staff of the Grande Prairie Municipal Hospital.

MANITOBA

BRANDON: The Graduate Nurses Association held its regular monthly meeting at the home of Dr. and Mrs. S. Pierce when, after a short business meeting, a social evening was enjoyed, the entertainment being in the hands of the "married ladies" group, and the guests of honour being the doctors and their wives. Those contributing to the programme were Miss M. Finlayson and Dr. S. Bolton, Miss O'Donnell and the Misses Peggy Doran and Shielia Nixon. The evening closed with dancing and games.

The Association held a surprise party in the Nurses Residence recently in honour of Miss C. Lynch and Mrs. Lawson Ferrier, who are leaving Brandon. Miss Lynch goes to the Mental Hospital at Ponoka, Alberta, to assume the position of superintendent of nurses, and Mrs. Ferrier will reside in Edmonton. The good wishes of the members were expressed by Miss M. Gemmell, who, with Miss C. Macleod presented Miss Lynch with a silver basket and Mrs. Ferrier with a silver cake plate as tokens of remembrance from the Association.

A farewell dance, honouring Miss C. Lynch, was held at the Nurses Residence of the Mental Hospital, when Dr. T. A. Pincock, on behalf of the members of the staff of the hospital, presented Miss Lynch with a set of silver toiletware and a bouquet of roses.

GENERAL HOSPITAL, WINNIPEG: Miss Margaret McClung (1917), of Brandon, Miss Louise Newcombe (1911), of St. Luke's Hospital, Duluth, Minn., and Miss Mabel Stutter (1919), of Henry Ford Hospital, Detroit, Mich., visited in Winnipeg during the Christmas season.

The Alumnae Association entertained at the home of Mrs. J. A. Davidson (Pearl Cameron, 1925), at a tea in honour of Miss Kathleen Ellis, recently appointed Superintendent of Nurses, Winnipeg General Hospital.

Mrs. A. D. Parker (Sylvia Haney, 1921), entertained the 1921 class at a shower during November in honour of Miss Myrtle Knittel, whose wedding took place in December.

NEW BRUNSWICK

CHIPMAN MEMORIAL HOSPITAL, ST. STEPHEN: Miss L. Mersereau has accepted the position of night supervisor of the Chipman Memorial Hospital, succeeding Miss Bessie Banfill, who has taken a position in the Magdalen Islands. Before leaving, Miss Banfill was guest of honour of the staff of the hospital, when she was presented with a handsome bathrobe and slippers. Miss Florence Cunningham, instructor, recently donated one hundred dollars to the Elevator Fund. This Fund was started with a gift of money from a patient, and the object is an electric elevator for the hospital. Miss Alice Powers, who has spent the past year with her sister, Mrs. Harry Simmons, has accepted the position of public health nurse in Fairfield, Maine, for three months.

Miss Margaret McFarlane, who has been visiting her parents in St. Stephen, is now relieving the V.O.N. nurse in Digby, N.S., for three months.

HOTEL DIEU HOSPITAL, CHATHAM: No effort was spared by the members of the staff to make Christmas Day in the hospital a happy one for the patients. Garlands of red and green were hung in the rooms and corridors and gaily decorated Christmas trees stood on each floor. Santa Claus was impersonated by the ladies of the Hospital Aid who came heavily laden with gifts and good things, bringing something for every occupant of the hospital. Early Christmas morning cheery carols were sung and later in the day the Sisters' choir with the accompaniment of organ and violin rendered beautiful Christmas hymns. Bountiful meals on dainty trays was another feature of the day, and the sunny afternoon brought numerous visitors.

ONTARIO

Paid-up subscriptions to "The Canadian Nurse" for Ontario, in January, 1931, were 1,192, four more than in December, 1930.

APPOINTMENTS

Miss Martha Simmerling (Grant MacDonald Training School, Toronto, 1930), to the Construction Hospital, Homer, Ont. Misses Irene Breckenridge and Helen Babcock (Kingston General Hospital), to the staff, Kingston General Hospital. Miss Pearl Reid to night supervisor, Kingston General Hospital, Isolation Hospital. Miss Miriam Michell (Kingston General Hospital, 1927), to Victorian Order of Nurses in Pictou, N.S. Miss Mabel Grant (Brockville General Hospital, 1930), to the staff of the hospital at West Hudson, Kearny, N.J. Miss Lillian Hinton (Oshawa General Hospital, 1928), has resigned from the staff of the Toronto General Hospital, having been appointed instructor of nurses at the Oshawa General Hospital. Miss Laura Webb (Toronto Western Hospital, 1919), has resigned her duties with the

Social Service Department at Belleville, Ont., and accepted a position with the Public Health Department at Toronto.

DISTRICT 1

VICTORIA HOSPITAL, LONDON: Miss Della Foster was re-elected President of the Alumnae for a third term when the annual meeting was held recently at the Gartshore Nurses Residence. The First Vice-President for 1931 is Miss Stuart, Second Vice-President Miss Hueston; Treasurer, Miss C. Gillies; Secretary, Mrs. Detiviler; Mrs. Millard, Corresponding Secretary; Miss Richmond, Representative to "The Canadian Nurse," and Miss Mary McVicar, Representative to the Registry Board. Directors named are: Miss Mary Yule, Miss Edith Smallman, Mrs. Hedley Smith, Miss L. McGuggan, Miss McDougall, and Miss Cryderman. Miss Mary Jacobs, Miss Mabel Hardie and Miss Mildred Thomas were appointed as Alumnae Representatives to the London Council of Social Agencies. The annual reports for 1930 showed a year of gratifying activity.

FLORENCE NIGHTINGALE ASSOCIATION, WINDSOR: Mrs. Haygarth, of the Provincial Health Department, Toronto, was the guest speaker for the January meeting of the Florence Nightingale Association of Windsor and adjacent municipalities, which was held in the Prince Edward Hotel. Mrs. Haygarth's talk, entitled "The Gift of Life," which was illustrated with moving pictures, was much appreciated. A report of the year 1930 shows much activity in the Association. Monthly dinner meetings were held throughout the year. These were well attended and usually followed by a musical programme or bridge, and were a splendid welcome to new members. Many interesting talks were given throughout the year by various members of the Association and guest speakers. On May 12th, 1930, the "Fourth Banquet" of the Association was held, the guest speaker being Miss Barbara Bartlett, Professor of Public Health, Ann Arbor University, Mich., whose topic was "Florence Nightingale, Pioneer in Public Health". Before disbanding for the summer months, the annual picnic was held at Boblo Island. Several of the members gave assistance to the V.O.N. Tag Day in October, and a baby's outfit was contributed to the Home and School Club of Tuscarora School for demonstration purposes. On November 4th a tea and sale of cakes was held, each member bringing a guest. This was a decided success. Two weeks later a rummage sale was held, and baby clothes were contributed by members to V.O.N. Headquarters for distribution to needy cases. Christmas cards were sent to each patient in the Metropolitan Hospital, and flowers to the nurses room there; a barrel of apples to the children at the Essex County Sanatorium; a cheque to the Goodfellow Club; and a cheque to the Rector of St. Mark's Church for the soup kitchen there.

DISTRICT 4

GENERAL HOSPITAL, HAMILTON: Miss Hazel Tilling (1925), is in charge of a private floor in Geneva Hospital, Geneva, N.Y. A very successful bazaar in aid of the Mutual Benefit Fund was held in the Senior Residence on November 5th, 1930.

DISTRICT 5

GRANT MACDONALD TRAINING SCHOOL, TORONTO: The Alumnae held a concert and dance recently in the nurses residence, the proceeds of which will be devoted to the Benefit Fund. Miss Ethel Cousineau and Miss Phylis Ebert (1930), are taking a post graduate course in obstetrics at the Women's Hospital, Detroit, Mich.

WESTERN HOSPITAL, TORONTO: The annual meeting of the Alumnae Association was held on December 9th, 1930, in the Edith Cavell Residence. Reports were read from various committees and the officers for 1931 were appointed. Miss Elizabeth McDiarmid (1910), addressed the meeting.

Mrs. Elizabeth Duff (1920), has resigned her duties as operating room supervisor at the Strathcona Hospital, Toronto.

GENERAL HOSPITAL, OSHAWA: At the November meeting of the Alumnae, Dr. O. G. Mills gave a very interesting talk on "Laboratory Technique" which was much appreciated by those present. At a special meeting held on December 8th, 1930, the nurses decided to hold their annual "At Home" in the Masonic Temple on January 22nd.

DISTRICT 6

NICHOLLS HOSPITAL, PETERBORO: The Alumnae entertained about seventy guests on the occasion of their annual banquet, which was held in the Empress Hotel on December 3rd, 1930. Solos were rendered during the evening by Miss Joey and Miss Parsons, members of the Alumnae, and Miss McIndoo, Superintendent of Belleville General Hospital. A humorous reading was given by Miss Watson, and this was followed by the presentation of a silver flower basket of mums to Miss Dixon, retiring President, in appreciation of her services to the Alumnae. The rest of the evening was spent in taking an imaginary trip to Alaska and back under the supervision of Dr. H. M. Yelland, with the assistance of moving pictures which were taken during his vacation last year.

GENERAL HOSPITAL, BELLEVILLE: A very successful rummage sale was held by the graduate nurses on November 19th, 1930.

DISTRICT 7

The regular meeting of District No. 7 was held in the Nurses Residence, Kingston General Hospital, on November 28th, 1930. After an interesting business meeting, Dr. Wm. Hay, of Queen's University, gave an instructive address on Immunization. Tea was served by the staff of the Kingston General Hospital.

GENERAL HOSPITAL, BROCKVILLE: The sympathy of the Alumnae is extended to

Miss Cornellia Sheridan and Miss Jennie McLaughlin on the death of their father.

GENERAL HOSPITAL, KINGSTON: The annual meeting of the Alumnae was held on December 9th, 1930, in the nurses residence. New officers were chosen and plans were made for the work of the coming year. Arrangements were made for the distribution of Christmas cheer, and donations this year to the different organisations were increased. Miss Bertha Maley has resigned her position as Maternity Supervisor. Miss Olive Cain and Miss Ena Bigford are doing general duty at the Roosevelt Hospital, New York City. On account of ill health, Miss Elizabeth Houston has had to resign her position as night supervisor of the Isolation Hospital

DISTRICT 8

Members of R.N.A.O. District No. 8 held an interesting meeting on November 6th, 1930, at the Ottawa General Hospital. Reports of the Canadian Nurses Association biennial meeting in Regina, an address on "How to Spend and Save," by Mr. H. E. North, Third Vice-President of the Metropolitan Life Assurance Company, and an interesting talk by Miss Gertrude Bennett on "The Requirements of Education of Nurses" added much to the meeting.

On October 25th, 1930, at the Chelsea Club, Ottawa, a meeting was held by the Public Health Section of District No. 8. About sixty nurses were present, the following groups of public health workers being represented: city nurses, school nurses, Provincial Department of Health, Victorian Order of Nurses and industrial nurses. Following the dinner, Dr. A. Grant Fleming, Professor of Public Health and Preventive Medicine at McGill University, addressed the meeting on "The Role of the Public Health Nurse in the Control of Communicable Disease." Dr. T. A. Lomer gave a graphic picture of present conditions in Ottawa regarding communicable diseases, particularly diphtheria. Dr. Paul Oloney, District Medical Officer of Health, spoke briefly on the diphtheria immunization campaign being launched in a district outside of Ottawa under the auspices of, and by the help of, the Ottawa Branch of the Victorian Order of Nurses. At the close of the meeting, those present recorded by a standing vote their willingness to support this campaign.

Descendant of Sir Isaac Brock and wartime nurse was the distinguished record of Mrs. S. C. Archibald, formerly Miss Louise Brock, who died in Saskatoon on October 24th, 1930, after a two days' illness. The late Mrs. Archibald received her training at St. Luke's Hospital, Ottawa, and served overseas with the No. 1 Canadian Nursing Division. She was President of the Women's Association of Saskatoon.

CIVIC HOSIPTAL, OTTAWA: A delightful bridge party was given by the Alumnae, the guests being received by Mrs. P. W. Dunning, President, and Miss Gertrude Bennett, Superintendent of Nurses. Dainty refreshments were served by the members. Miss Margaret McCallum was convener and her assistants were Misses E. Curry, Beth Graylin, Ruth Bell, Wynn Drake and D. Gorman.

GENERAL HOSPITAL, OTTAWA: The Alumnae Ball of the Ottawa General Hospital was held on November 18th, 1930, in the Chateau Laurier. Several hundred guests attended. The conveners were Misses Margaret Flynn and Florence Nevins, assisted by Misses Rose Fitzimmons, Y. Letellier, B. Belier, K. Keane, J. Robert, A. Lapointe, M. Munroe, P. Bissonnette and M. Chartrand and Mrs. A. J. McEvoy.

PRINCE EDWARD ISLAND

GRADUATE NURSES ASSOCIATION: Miss Millicent Mutch has returned to Prince Edward Island after a pleasant visit at Vancouver, B.C. Miss Jennie Hardy has returned after spending the past year at Edmonton, Alta. Miss Hardy has accepted a position with the Poly Clinic at Charlottetown. Miss Victoria Watts has returned from a brief visit to Boston, Mass. Miss Annie MacDonald and Miss Veda Lamont have resumed their duties at New Rochelle, N.Y., after spending a pleasant holiday on Prince Edward Island. Miss Ella B. Saint (Prince Edward Island Hospital, Charlottetown, 1930) has accepted a position as night supervisor at the Prince County Hospital, Summerside, P.E.I.

QUEBEC

GENERAL HOSPITAL, MONTREAL: The annual meeting of the Alumnae Association was held on January 9th, 1931. Miss Holt, retiring President, gave a most inspiring address in which she stressed the importance of all members subscribing to "The Canadian Nurse". The report of the Treasurer, Miss Davis, was very satisfactory, showing a surplus both in the Alumnae Association and in the Mutual Benefit Association.

Miss Marion Boa (1919), has gone to New Glasgow, N.S., to act in an advisory capacity and to assist in the re-organisation of the training school of the Aberdeen Hospital.

CHILDREN'S MEMORIAL HOSPITAL, MONTREAL: The Alumnae extends to Miss Grace Murray (1927), deepest sympathy on the death of her father.

Institute of Public Health
Faculty of Public Health of the
University of Western Ontario
LONDON - CANADA

BIRTHS, MARRIAGES AND DEATHS

BIRTHS

BALFOUR—On December 10th, 1930, at Regina, to Mr. and Mrs. William Balfour (Goldie McDonald, Regina General Hospital, 1915) a daughter.

BORHAM—On November 21st, 1930, to Mr. and Mrs. H. H. Borham (Julia Swanson, Winnipeg General Hospital, 1928) a son.

CAMPBELL—On November 10th, 1930, at Uigg, P.E.I., to Mr. and Mrs. John Campbell (Edith MacNeill, Prince Edward Island Hospital, Charlottetown, P.E.I., 1923), a son.

CROFT—Recently, at Oshawa, Ont., to Mr. and Mrs. Richard Croft (Frances Smith, Oshawa General Hospital, 1925), a daughter.

DAY—Recently, to Mr. and Mrs. Harold Day (Edith Allen, Victoria Hospital, London, Ont., 1928), a daughter.

GIBBS—On December 7th, 1930, at Ottawa, to Mr. and Mrs. Harry Gibbs (Amy Poff, Grant MacDonald Training School, Toronto, 1928), a son.

HENDERSON—On November 16th, 1930, at Regina, Sask., to Mr. and Mrs. A. Henderson (Sue Wright, Royal Jubilee Hospital, Victoria, B.C., 1922), a daughter.

KNOWLES—On December 17th, 1930, at Ottawa, Ont., to Mr. and Mrs. George Knowles (Gladys Winters, Ottawa Civic Hospital, 1929), a son.

MAWSON—On December 14th, 1930, at Hamilton, Ont., to Mr. and Mrs. Charles Mawson (Dorothy Jackson, Hamilton General Hospital, 1926), a son.

MAXWELL—On December 15th, 1930, at Vancouver, to Mr. and Mrs. John Maxwell (Doris Cowley, Vancouver General Hospital), a daughter.

MOLKE—On December 1st, 1930, at New Milford, N.J., to Mr. and Mrs. H. E. Molke (Ethel Johnson, Grant MacDonald Training School, Toronto, 1928), twin sons.

MURCHISON—On August 14th, 1930, at Belfast, P.E.I., to Mr. and Mrs. Angus Murchison (Eva Ross, Prince Edward Island Hospital, Charlottetown, P.E.I., 1925), a son.

ORRILL—On November 30th, 1930, at Belleville, Ont., to Mr. and Mrs. Jack Orrill (Flossie Hannah, Belleville General Hospital, 1923), a son.

READ—Recently, at London, Ont., to Dr. and Mrs. Art Read (Kay Hyatt, Victoria Hospital, London, Ont., 1924), a son.

REGAN—On November 14th, 1930, at Hamilton, Ont., to Mr. and Mrs. Lloyd Regan (Jean Forsythe, Hamilton General Hospital, 1926), a son.

ROBINSON—On December 8th, 1930, at Regina, Sask., to Mr. and Mrs. Homer Robinson (Lucy Allingham, Regina General Hospital, 1925), a son.

ROSS—On December 5th, 1930, at Regina, Sask., to Mr. and Mrs. D. D. Ross (Irene McLanders, Regina General Hospital, 1919), a son.

SANDELL—On December 1st, 1930, to Mr. and Mrs. Gordon Sandell (Eileen Le Mesurier, Regina General Hospital, 1928), a son.

SANDERSON—Recently, at London, Ont., to Mr. and Mrs. N. Sanderson (B. Smith, Victoria General Hospital, London, Ont., 1920), a daughter.

SHORE—On November 28th, 1930, at Ottawa, to Mr. and Mrs. J. W. Shore (Stella Ashfield, St. Luke's Hospital, Ottawa, 1918), a daughter.

SMITH—On November 24th, 1930, at Huntington, Va., to Rev. and Mrs. Wm. Smith (Ruth Welstead, Toronto Western Hospital, 1918), a daughter.

SPAFFORD—On June 7th, 1930, at Toronto, to Mr. and Mrs. Earl Spafford (Evelyn Stinson, Grant MacDonald Training School, Toronto, 1929), a son.

SPEIRS—On November 15th, 1930, at Winnipeg, Man., to Mr. and Mrs. Alex. Speirs (Helen Lambert, Winnipeg General Hospital, 1917), a son.

STYLES—On November 1st, 1930, at Regina, Sask., to Mr. and Mrs. George Styles (Ella Mathews, Maple Creek Hospital, Maple Creek, Sask., 1916), a daughter.

SUTHERLAND—On November 24th, 1930, at Cookstown, Ont., to Mr. and Mrs. Sandford J. Sutherland (Margaret Gladys McCullough, Toronto Western Hospital, 1925), a daughter.

TODD—On September 16th, 1930, at Brockville, Ont., to Mr. and Mrs. John Todd (Luella Heagle, Brockville General Hospital, 1926), a son.

WEESE—On December 7th, 1930, at Belleville, Ont., to Mr. and Mrs. Harold Weese (Olive Brodshaw, Belleville General Hospital, 1923), a daughter.

WILSON—On December 8th, 1930, at Campbell's Bay, P.Q., to Mr. and Mrs. Asa Wilson (Marie J. Smith, Ottawa Civic Hospital, 1923), a daughter.

MARRIAGES

AITKEN—SHAW—In June, 1930, at Charlottetown, P.E.I., Mabel Shaw (Prince Edward Island Hospital, Charlottetown, 1929) to Reginald Aitken.

BATEMAN—KIRK—In July, 1930, Minnie Kirk (General and Marine Hospital, Owen Sound, Ont., 1927) to Wm. Bateman, of Kitchener, Ont.

BUCKNAM—TRAQUAIR—On December 8th, 1930, at Hamilton, Ont., Margaret Traquair (Vancouver General Hospital) to Earl Bucknam.

Institute of Public Health
Faculty of Public Health of the
University of Western
LONDON

CHRISTIAN—GRIMES — In November, 1930, at St. Johns, Nfld., Emma Grimes (Children's Memorial Hospital, Montreal, 1930) to T. M. Christian, of St. Johns, Nfld.

CAMPBELL—SEAFOOT — On December 20th, 1930, at Medicine Hat, Alta., Emma Seafoot (Medicine Hat General Hospital, 1928) to Dr. Wilfred C. Campbell, of Medicine Hat.

CLARKE—BISHOP — On October 15th, 1930, at Wellington, P.E.I., Grace Bishop (Prince Edward Island Hospital, Charlottetown, 1926) to Norman Clarke, of St. John, N.B.

COFFIN—PIGOTT—In July, 1930, Millie Pigott (Prince Edward Island Hospital, Charlottetown, 1923) to Chester Coffin, of Brookline, Mass.

FLYNN—WILLIAMSON — On December 15th, 1930, at Ogdensburg, N.Y., Mabel Gertrude Williamson (Lady Stanley Institute, Ottawa) to Arthur Flynn, of Morrisburg, Ont.

GILLINGER—WILLIARD — Recently, at Flint, Mich., Grace Williard (Victoria Hospital, London, Ont., 1927) to Dr. F. Gillinger.

GRAY—MALEY—On December 25th, 1930, at Winnipeg, Bertha Maley (Kingston General Hospital, Kingston, Ont., 1927) to Rev. Albert M. J. Gray, of McCready, Man.

HOOD—KNOX—On December 20th, 1930, at Harrisburg, Ont., Hazel Knox (Hamilton General Hospital, 1929) to Roy Hood.

HOWLAND—DEAKIN—On December 8th, 1930, at The Pas, Man., Kathleen E. Deakin (Vancouver General Hospital, 1927) to Harold E. Howland, of Churchill, Man.

JACKS—GOODFELLOW — On December 17th, 1930, at Toronto, Isabel Goodfellow (Hamilton General Hospital, 1930) to Wilfred Jacks, of Stroud, Ont.

MATHESON—MacKINNON — On June 17th, 1930, at Charlottetown, P.E.I., Louise MacKinnon (Prince Edward Island Hospital, Charlottetown, 1929) to David Matheson, of Montague, P.E.I.

MATHESON — MASON — On September 23rd, 1930, at Bunbury, P.E.I., Bertha Lois Mason (Prince Edward Island Hospital, Charlottetown, 1924) to Stanley Matheson, of Charlottetown, P.E.I.

McADAM—AYERST—On November 7th, 1930, at Kapuskasing, Ont., Hilda Maud Ayerst (Hamilton General Hospital, 1920) to Bruce McAdam, M.A., of Brantford, Ont.

McDONALD—STODDARD—On October 11th, 1930, at Detroit, Mich., Doris Stoddard (Victoria Hospital, London, Ont., 1928) to Frank McDonald.

PRITCHARD—DONALDSON—On November 8th, 1930, at Newington, Ont., Aileen Donaldson (St. Luke's Hospital, Ottawa) to John R. Pritchard, M.D., of Ottawa.

RALPH—MOWAT—On December 10th, 1930, at Ottawa, Evelyn C. Mowat (Ottawa Civic Hospital, 1930) to Orrville A. Ralph, of Stittsville, Ont.

RITCHIE — RAEBURN — On December 24th, 1930, at Montreal, Margaret A. Raeburn (Montreal General Hospital, 1925) to Dr. Robert N. Ritchie, of Rochester, N.Y.

SIGVALDASON—McLEOD — On December 16th, 1930, at Winnipeg, Florence McLeod (Winnipeg General Hospital, 1928) to Dr. Sigvaldason.

SMITH—GREIG—On December 31st, 1930, at Coppercliffe, Ont., Margaret Greig (Toronto Western Hospital, 1929) to Harry W. Smith.

WALMSLEY—FLOYD — On December 23rd, 1930, at Winnipeg, Mary Floyd (Winnipeg General Hospital, 1927) to Major Frank Walmsley.

WAUGH—ROSS—On November 29th, 1930, at Deloraine, Man., Marjorie Ross (Winnipeg General Hospital, 1929) to Heber E. Waugh.

WEEKES — BARTRAM — On November 8th, 1930, at Ottawa, Bernice Bartram (Ottawa Civic Hospital, 1926) to Ludlow Weekes, of Ottawa.

WHITTON—KNITTEL — In December, 1930, at Detroit, Mich., Myrtle Knittel (Winnipeg General Hospital, 1931) to F. E. Whitton, of Detroit, Mich.

WRIGHT—VICKERSON—On September 18th, 1930, at Tryon, P.E.I., Marion Vickerson (Prince Edward Island Hospital, Charlottetown, 1923) to David Wright, of Montague, P.E.I.

DEATHS

BEATTY—On November 26th, 1930, at Owen Sound, Ont., Effie Greig (Fergus General Hospital, Fergus, Ont.), wife of Reginald Beatty, in her twenty-ninth year.

BOWEN—On December 19th, 1930, at Wheatley River, Florence Bowen (Prince Edward Island Hospital, Charlottetown, 1925), after a lingering illness.

NASH—On January 5th, 1931, at Medicine Hat, Alta., Alice Florence Nash (Medicine Hat General Hospital, 1919).

SCHNEIDER—On December 31st, 1930, at Montreal, Miss Maude Schneider (Montreal General Hospital, 1898).

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DISTRICT No. 10, REGISTERED NURSES ASSOCIATION OF ONTARIO

Chairman, Miss A. Boucher; First Vice-President, Mrs. F. Edwards; Second Vice-President, Miss M. Flannigan; Secretary-Treasurer, Miss R. Wade; Conveners of Committees: Nursing Education, Miss B. Bell; Public Health, Miss V. Lovelace; Private Duty, Miss I. Sheehan; Publication, Miss J. Hogarth; Membership, Miss C. McNamara, Miss M. Hetherington; Social, Miss M. Racey, Miss V. Lovelace; Representative to Board of Directors Meeting R.N.A.O., Miss A. Boucher.

Meetings held first Thursday every month.

A.A., BELLEVILLE GENERAL HOSPITAL

Hon. President, Miss Florence McIndoo; President, Miss H. Stacey; Vice-President, Miss A. Derbyshire; Secretary, Miss B. Cryderman; Treasurer, Miss V. Babcock; Flower Committee, Miss H. Fitzgerald; Representative, "The Canadian Nurse," Mrs. C. Arnott.

Regular meeting held first Tuesday in each month at 3.30 p.m. in the Nurses' Residence.

A.A., BRANTFORD GENERAL HOSPITAL

Hon. President, Miss E. Muriel McKee, Superintendent; President, Miss Marion Cuff; Vice-President, Miss Madeline Waghorn; Secretary, Miss Hilda Muir; Asst. Secretary, Miss Natalie Lockman; Treasurer, Miss Jean Davidson; "The Canadian Nurse" Representative, Miss Nellie Yardley; Press Representative, Miss Anne Hardisty; Flower Committee, Miss Ida Martin, Miss Florence Stuart; Gift Committee, Mrs. D. A. Morrison, Mrs. A. A. Matthews; Social Convener, Mrs. W. H. Langton.

A.A., BROCKVILLE GENERAL HOSPITAL

Hon. President, Miss A. L. Shannette; President, Mrs. H. B. White; First Vice-President, Miss M. Arnold; Second Vice-President, Miss J. Nicholson; Third Vice-President, Mrs. W. B. Reynolds; Secretary, Miss B. Beatrice Hamilton, Brockville General Hospital; Treasurer, Mrs. H. F. Vandusen, 65 Church St.; Representative to "The Canadian Nurse," Miss V. Kendrick.

A.A., ST. JOSEPH'S HOSPITAL, CHATHAM, ONT.

Hon. President, Mother St. Roch; Hon. Vice-President, Sister M. Loretta; President, Mrs. Pearl Johnston; Vice-President, Miss Jean Lundy; Secretary, Miss Irene Gillard, 52 Raleigh St., Chatham; Treasurer, Miss Jean Bagnell; Executive, Misses Jessie Ross, Katherine Dillon and Agnes Harrison; Flower Committee, Miss Felice Richardson and Mona Middleton; Representative to "The Canadian Nurse," Miss Jessie Ross; Representative, District No. 1, R.N.A.O., Miss Hazel Gray.

A.A., CORNWALL GENERAL HOSPITAL

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A.A., HAMILTON GENERAL HOSPITAL

Hon. President, Miss E. C. Rayside, Hamilton General Hospital; President, Miss Annie B. Boyd, 607 Main St. E.; Vice-President, Miss M. Buchannan, Hamilton General Hospital; Treasurer, Miss E. Bell, 1 Cumberland; Recording Secretary, Miss B. Aitken, 44 Victoria Ave. S.; Secretary-Treasurer Mutual Benefit Association, Miss L. Hannah, 25 West Ave. S.; Executive Committee, Mrs. N. Barlow (Convener), 211 Stenson St., Misses E. Baird, C. Chappel, M. Pegg, Mrs. E. Johnson; Programme Committee, Miss Mary Ross (Convener), Misses M. Watt, H. Baker, E. Davidson, J. Lenz, M Harvey, C. Currah, Blanche Pond; Flower and Visiting Committee, Miss Sturrock (Convener), Misses Squires, Blanchard, Burnett. Representatives to Local Council of Women, Mrs. Hess, Misses Harley, Buckbee, Burnett; Representative to R.N.A.O., Miss G. Hall; Representatives to "The Canadian Nurse," Miss Buscombe (Convener), Misses Strachan and Carruthers; Representative to Women's Auxiliary, Mrs. J. Stephen; Registry Committee, Mrs. Hess (Convener), Misses Nugent, Hack, Gringer.

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A.A., HOTEL DIEU, KINGSTON, ONT.

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A.A., KINGSTON GENERAL HOSPITAL

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A.A., ST. JOSEPH'S HOSPITAL, LONDON, ONT.

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A.A., NIAGARA FALLS GENERAL HOSPITAL

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A.A., ORILLIA SOLDIERS' MEMORIAL HOSPITAL

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Regular Meeting—First Thursday of each month.

A.A., OSHAWA GENERAL HOSPITAL

Hon. President, Miss MacWilliams; President, Miss Ann Scott, 108 Division St., Oshawa; Vice-President, Mrs. E. Hare; Second Vice-President, Miss Olive Hanna; Secretary, Miss Elma Hogarth, 301 Celina St., Oshawa; Asst. Secretary, Mrs Douglas Redpath; Corresponding Secretary and Press Representative, Miss Robena Buchanan, 564 Mary St., Oshawa; Treasurer, Miss Jane Cole; Social Convener, Miss Ruby Berry; Visiting and Flower Convener, Miss Helen Hutchison; Convener, Private Duty Nurses, Miss Margaret Dickie; Representative, Hospital Auxillary, Mrs. B. A. Brown, Mrs. M. Canning, and Mrs. E. Hare.

A.A., ST. LUKE'S HOSPITAL, OTTAWA

Hon. President, Miss Maxwell; President, Miss Doris Thompson; Vice-President, Miss Diana Brown; Secretary, Miss Isobel Allan, 408 Slater Street, Ottawa; Treasurer, Mrs. Florence Ellis; Nominating Committee, Misses Mina MacLaren, Hazel Lyttle, Katherine Tribble.

A.A., LADY STANLEY INSTITUTE, OTTAWA (Incorporated 1918)

Hon. President, Miss M. A. Catton, 2 Regent St.; Hon. Vice-President, Miss Florence Potts; President, Miss Mabel M. Stewart, Royal Ottawa Sanatorium; Vice-President, Miss M. McNiece, Perley Home, Aylmer Ave.; Secretary, Mrs. G. O. Skuce, Britannia Bay, Ont.; Treasurer, Miss C. Slinn, 204 Stanley Ave.; Board of Directors, Miss E. MacGibbon, 114 Carling Ave.; Miss C. Flack, 152 First Ave.; Miss E. McColl, Vimy Apts., Charlotte St.; Miss L. Belford, Perley Home, Aylmer Ave.; "Canadian Nurse" Representative Miss A. Ebbs, 80 Hamilton Ave.; Representatives to Central Registry Nurses, Miss A. Ebbs, 80 Hamilton Ave.; Miss Mary C. Slinn, 204 Stanley Ave.; Press Representative, Mrs. J. Waddell, 220 Waverley St.

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A.A., OTTAWA GENERAL HOSPITAL

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A.A., GRANT MACDONALD TRAINING SCHOOL FOR NURSES, TORONTO, ONT.

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A.A., TORONTO ORTHOPEDIC HOSPITAL TRAINING SCHOOL FOR NURSES

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A.A., RIVERDALE HOSPITAL, TORONTO

President, Miss E. Lyall, 290 St. George St., Toronto; First Vice-President, Miss G. Gastrell, Isolation Hospital; Second Vice-President, Mrs. Radford, 458 Strathmore Blvd.; Secretary, Miss Cora L. Russell, Isolation Hospital; Corresponding Secretary, Mrs. E. Quirk, Isolation Hospital; Treasurer, Miss L. McLaughlin, Isolation Hospital; Conveners of Standing Committees: Sick and Visiting, Miss S. Stretton, 7 Edgewood Ave.; Programme, Miss K. Mathieson, Isolation Hospital; Representatives to Central Registry, Misses G. Anderson, J. Henderson.

A.A., HOSPITAL FOR SICK CHILDREN, TORONTO

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A.A., ST. JOHN'S HOSPITAL, TORONTO

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A.A., ST. JOSEPH'S HOSPITAL, TORONTO, ONT.

Hon. President, Rev. Sister M. Melanie; President, Miss E. Morrison, 1543 Queen Street West, Toronto; First Vice-President, Miss A. O'Neill; Second Vice-President, Miss L. Boyle; Treasurer, Miss M. Heary, 158 Marion Street, Toronto; Recording Secretary, Miss R. Rouse; Corresponding Secretary, Miss O. MacKenzie, 43 Lawrence Avenue West, Toronto; Councillors, Misses O. Kidd, M. Howard, V. Sylvain, G. Davis; Constitutionals, Misses A. Hihn, M. Howard, L. Boyle; Programme Committee, Misses R. Jean-Marie, L. Dunbar, I. Voisin.

A.A., ST. MICHAEL'S HOSPITAL, TORONTO

President, Miss Essie Taylor, 20 Lauder Ave., Toronto; First Vice-President, Miss Ella Graydon; Second Vice-President, Miss Ella O'Boyle; Third Vice-President, Miss Helen O'Sullivan; Recording Secretary, Miss Roselle Grogan; Corresponding Secretary, Miss Marie E. McEnaney, 62 Ariel St., Toronto; Treasurer, Miss Helen Hyland, 137 Belsize Drive, Toronto; Directors, Misses E. M. Chalue, M. I. Foy, Marcella Berger; Conveners of Standing Committees, Misses Ivy de Leon, Julia O'Connor, Hilda Kerr.

A.A., VICTORIA MEM. HOSPITAL, TORONTO

Hon. President, Mrs. Forbes Godfrey; President, Miss Annie Pringle; Vice-President, Miss Dorothy Greer; Secretary, Miss Florence Lowe, 152 Kenilworth Ave., Toronto; Treasurer, Miss Ida Hawley, 41 Gloucester St., Toronto.

Regular Meeting—First Monday of each month.

A.A., WELLESLEY HOSPITAL, TORONTO

President, Miss Edith Carson, 499 Sherbourne St.; Vice-President, Miss Ruth Jackson, 80 Summerhill Ave.; Treasurer, Miss Lucille Thompson, 4, 118 Isabella St.; Recording Secretary, Miss Mildred McMullen, 133 Isabella St.; Corresponding Secretary, Miss Evelyn McCullough, 1117 Danforth Ave.; Executive, Misses Edna Tucker, Betty Scott, Doris Anderson, Audrey Lavelle; Correspondent to The Canadian Nurse, Miss Waple Greaves, 65 Glendale Ave.

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Meetings will be held the second Tuesday in each month at 8 p.m. in the Assembly Room, Nurses' Residence, Toronto Western Hospital.

A.A., WOMEN'S COLLEGE HOSPITAL, TORONTO

Hon. President, Miss Harriett T. Meiklejohn; President, Miss Vera Allèn; Vice-President, Miss Munns; Recording Secretary, Miss Bankwitz; Corresponding Secretary, Miss McAughtrie; Treasurer, Miss Bessie Fraser; Representatives to Central Registry, Miss Kidd, Miss Bankwitz; "The Canadian Nurse" Representative, Miss E. E. K. Collier, 45 Dixon Avenue, Toronto, Ont.

Meetings will be held the second Monday in each month.

A.A., CONNAUGHT TRAINING SCHOOL FOR NURSES, TORONTO HOSPITAL, WESTON

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A.A., GENERAL HOSPITAL, WOODSTOCK

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A.A., LACHINE GENERAL HOSPITAL

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Meeting—First Monday of each month, at 9 p.m.

Institute of Public Health
Faculty of Public Health of the
University of Western Ontario
LONDON - CANADA

MONTREAL GRADUATE NURSES' ASS'N.

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Regular Meeting—First Tuesday, January, April, October, and December.

A.A., CHILDREN'S MEM. HOSP., MONTREAL

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A.A., MONTREAL GENERAL HOSPITAL

President, Mrs. Allan; First Vice-President, Miss A. Jamieson; Second Vice-President, Miss M. Mathewson; Recording Secretary, Miss Inez Welling; Corresponding Secretary, Miss Anne Thorpe; Treasurer, Alumnae Association and Mutual Benefit Association, Miss Isabel Davies; Hon. Treasurer, Miss H. M. Dunlop; Executive Committee, Misses M. K. Holt, F. E. Strumm, J. Meigs, L. Urquhart, C. M. Watling; Representatives, Private Duty Section, Misses Morrison (Convener), R. Loggie, Melba Johnston, Winnifred Spier; Representatives to "The Canadian Nurse," Misses C. M. Watling (Convener), N. Kennedy-Reid, Ruth Hamilton; Representatives to Local Council of Women, Miss G. Colley(Convener), Miss Marjorie Ross (Proxy), Miss Harriett Ross; Sick Visiting Committee, Mrs. Stuart Ramsay Convener), Misses L. Shepherd, B. Noble; Refreshment Committee, Misses D. Flint(Convener), M. I. McLeod, Theodora McDonald, S. Fraser.

A.A., HOMOEOPATHIC HOSPITAL, MONTREAL

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A.A., ROYAL VICTORIA HOSPITAL, MONTREAL

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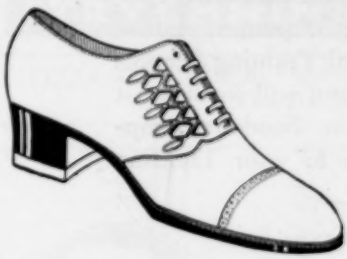

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